NATIONAL MINORITY AIDS COUNCIL

The Collaboration Continuum

1996 TECHNICAL ASSISTANCE MANUAL

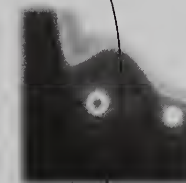


Table of Contents

Dear Colleague,

As we forge ahead toward the second millennium, the face of HIV/AIDS has taken on new dimensions, as well as new challenges. Among the most significant and extraordinary of these is the ever pressing need for community-based organizations to garner energy and stamina for the long haul.

The National Minority AIDS Council (NMAC) is committed to developing leadership within communities of color to address the challenges of HIV infection. Our continued work in the area of technical assistance and training is part of this commitment. This year, our team acknowledges the needs and requests of our constituents to better prepare for the future by exploring unique, innovative methods of working together to accomplish their mission.

The purpose of this ***Collaboration Continuum*** is to provide a variety of strategies to enhance the spirit of cooperation, a commendable trademark of many of our communities. For many, collaboration has served as a strengthening agent, affording us the opportunity to confront our visions boldly. An important step in this process is the development of HIV Prevention Community Planning, which is highlighted in this manual.

We would like to thank Michael Allison, Jan Masoka, Jude Kaye, and the staff of the Support Center of San Francisco for helping to bring this year's manual to fruition. A special thanks to Audrey Denson for her zest and devotion to this project. Her graphic design and creativity are a bonus to NMAC and the field. With great regard, we thank the Centers for Disease Control & Prevention whose funding support and collaboration made this manual possible. ✓

This manual is dedicated to all the leaders and institutions of color who strive so gallantly to inspirit this movement.

Yours in the struggle,

Paul Akio Kawata
Executive Director

Harold J. Phillips
Director, Technical Assistance

Jacqueline Coleman
Co-Director, Technical Assistance

Acknowledgments

Appropriately, this Manual is itself the product of a long-term collaboration between two nonprofits – NMAC and the Support Center for Nonprofit Management – and of the experience of HIV/AIDS organizations all over the country with whom we have had the honor of working as consultants.

Harold Phillips and Jackyie Coleman at NMAC have taken the lead in bringing this Manual to you, through their conversations with staff at the Centers for Disease Control, with others at NMAC and with us. Over the last several months, they have provided guidance, insight, resources, contacts, editing and support. To them both, we offer our deep appreciation.

Paul Kawata and Jude Kaye, who have helped create each of the previous three manuals NMAC and the Support Center have produced together, again played a critical role by helping to design the conceptual framework for the book, and by helping us turn concepts into practical guides and tips. We couldn't have done it without these two inspiring colleagues.

Several leaders of AIDS service organizations helped make this Manual come alive through sharing their experiences with collaborations and by providing advice of their own. This book is immeasurably enhanced by their contributions; thank you: Pua Aiu, DiAna DiAna, Melissa Bedford, Earl Fowlkes, Steve Lew, Lupe Lopez, Tony Morris, Norm Nickens, Elizabeth Norton Schaffer, and Pandora Singleton.

Finally, we want to thank all of the staff, board and volunteers of AIDS organizations across the U.S. who are struggling creatively to get more done with the limited resources available through working with others. It is to all of you we dedicate this Manual.

Michael Allison **Jan Masaoka**
San Francisco, 1996

Introduction

Although medical science continues to advance against the epidemic, AIDS service organizations are increasingly settling in for the long haul. New infections continue to ravage our communities. While people with HIV are achieving longer life expectancies and higher quality of life, new drugs are exorbitantly expensive and a true cure is still years away. Despite our increased advocacy and political clout, government funding will *always* be uncertain. Although there are increases and declines in specific foundation funding situations, overall private foundation and individual funding seems to be leveling off across the country.

As a result, the need to do more with less has never been stronger. In the past few years, "collaboration" has gone from being a forward-thinking concept to a commonplace activity. Organizations are collaborating more–with other organizations, with different kinds of organizations, and in different ways–than ever before.

The promise of collaboration is that it can help us do a better job *and* do it more efficiently. But collaboration is not a magic potion or cure-all. It isn't always successful, and isn't even always appropriate. Successful collaboration requires hard-headed planning with a longer view in mind. It requires negotiating skills and a strategic conceptualization of the collaborative options.

This Manual is designed to give you the tools for planning, choosing, and negotiating collaborations. The Manual provides a description of the many types of collaboration to assist your organization in recognizing and pursuing opportunities to better serve your communities. The information may be useful as part of a strategic planning process, an exploratory meeting with prospective partners, or to support collaborations already in place.

The fundamental principles of collaboration are presented with practical guidelines to support specific initiatives, from very informal networking to projects which require detailed written agreements and plans. Managing collaborative relationships requires particular skills and an awareness of power dynamics. Suggestions are offered in each of these areas to help develop successful collaborations.

HIV Prevention Community Planning pushes the edges of collaboration by attempting to involve a wider range of stakeholders in deciding government policy at state and local levels. Community planning is complex, tiring and often messy. Yet it offers the hope of making better use of all our resources, public and private, to stop the spread of this epidemic through coordinating the efforts of government, community-based agencies and members of our communities.

The section on community planning provides a road map for you as leaders of AIDS service organizations to begin, or expand, involvement in this important activity. In addition, you will find a sampling of the unique ways in which communities are discovering ways of bringing as many players to the table as possible, and ways of making the best decisions they can for their own communities.

Although the principles in this manual are applicable for all types of organizations, it was specifically written for volunteer and staff leaders of community-based AIDS service organizations. It is not a theoretical book about collaboration, nor will it provide an answer to every question. Instead, we hope it will act as a resource guide to help ASOs in making the most of the collaborative opportunities available to them.

The Collaboration Continuum

1. What is Collaboration?

- A Gallery of HIV/AIDS Collaborations
- Collaborations Discussed in This Manual
- A Word About Words
- The Collaboration Continuum
- Eight Myths About Collaboration

Some collaborations are informal and unstructured; others are highly formal and documented in signed, legal papers. All collaborations can be thought of as resting at different points in a broad continuum, ranging from low intensity with relatively little interaction to high intensity with a large degree of interdependence among the partners.

This section begins with a "gallery" of real-life collaborations in HIV/AIDS services and prevention, and goes on to construct a framework for the collaboration continuum.

A GALLERY OF HIV/AIDS COLLABORATIONS

The wide range of possible collaborations is illustrated in the following "gallery" of collaborations:

- The South Carolina AIDS Education Network, through its AIDS Busters program, joined with local youth groups, the housing authority and church groups to sponsor a one day conference for youth active or interested in doing peer AIDS prevention education:

➢ ***Collaboration can be a short term, high intensity, joint project***

- People of Color Against AIDS Network (POCAAN) in Seattle provides ten AIDS organizations working in specific ethnic populations with office space, telephone, postage, reception service, and fiscal management:

➢ ***Collaboration can be an ongoing, highly structured joint venture for resource sharing and operations***

- In San Francisco, the Asian AIDS Project, Filipino Task Force on AIDS and the Living Well Project coordinate referrals for Asian/Pacific Islander clients seeking a variety of HIV health and prevention services in different languages:

➢ ***Collaboration can be a low-visibility, informal arrangement with high impact for clients***

- Virginia Organizations Responding to AIDS (VORA) is a coalition of agencies which ensures that testimony is presented at appropriate city council hearings, and coordinates personal visits with Virginia General Assembly legislators by coalition members:

➢ ***Collaboration can provide a framework through which many agencies can amplify their public policy impact***

- Case managers from all AIDS agencies in Marin County, California, meet regularly and developed a standard Intake/Registration Form for use by clients registering for any AIDS-related service in Marin, eliminating the need for clients to go through an intake process more than once:

➢ ***A collaborative project can emerge from unstructured information sharing and networking among individuals***

- Begun as a collaboration among the Ryan White funded agencies in Cumberland County, New Jersey, the Martin Luther King, Jr. Academy now convenes monthly meetings with many local service providers including drug and alcohol programs, a local hospice, and youth groups in order to coordinate many levels of service delivery:

➢ ***Collaboration can involve many different kinds of partners***

- Across the country, literally hundreds of community planning groups exist which involve health departments, service providers, people with AIDS, scientists and other stakeholders. These groups (convened as a requirement of receiving federal Ryan White CARE Act funding), have brought about unprecedented coordination at the local, state and national level in all aspects of HIV and AIDS services:

➢ ***Collaboration can involve the entire community in setting priorities and seeking and distributing funding***

COLLABORATIONS DISCUSSED IN THIS MANUAL

In short, collaboration can be high or low intensity, informal or structured, ongoing or short term, involve two partners or many partners, and be organized for different ends. This Manual takes a broad, practical view of defining collaboration: to collaborate is simply: *"To work together, to cooperate."* As a result, simple networking and information sharing are discussed here, as well as sample Memoranda of Understanding for more formal collaborations. Mergers & consolidations are special cases because one or more organizations cease to exist in a merger process. However, the process for initiating and negotiating mergers is similar in most respects to other types of collaboration.

Also included in our discussion is the role of community planning. The extent and quality of participation by ASOs in hundreds of Ryan White and prevention planning councils represents an unprecedented and impressive form of community collaboration. Making the best use of these collaborative opportunities is an important task for AIDS service organizations.

A WORD ABOUT WORDS

How is "collaboration" defined?

Webster's New World Dictionary defines the word *collaborate* simply as "to work together." Microsoft Word's Thesaurus offers *to cooperate, to combine, to work together, to help.* The Amherst H. Wilder Foundation, in its publication "Collaboration: What Makes It Work," defines collaboration as: "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve results they are more likely to achieve together than alone." But, if you were to ask a member of the French Resistance during World War II to define "collaboration," you might get the heated response, "to work with the enemy, to be a traitor." Which one is right?

In this Manual we use a broad, inclusive definition of collaboration: *to work together, to cooperate.* The many different forms of "working together" have generated a confusing array of terms and definitions, used by different people to mean different things. All of these are included under the broad definition used in this Manual:

Networking	Making a point of knowing what others are doing and not doing, providing a basis for informed program development, fundraising, or action
Cooperation	Sharing information or working together
Coalition	A group of three or more organizations working for a common policy goal; can involve a formal commitment to the coalition, but usually does not involve transferring organizational resources between organizations
Consolidation	Reducing the number of distinct programs doing the same or similar service or different services to the same population; usually takes the form of acquisition or merger
Acquisition	One organization becomes responsible for ("acquires") a program (or all programs) formerly run by another organization; may involve transferring contracts, staff and other program resources from one organization to another
Merger	Two or more organizations join together to become one organization
Fiscal Agent	One organization acts as the legally incorporated, tax-deductible entity on behalf of a program or another organization

THE COLLABORATION CONTINUUM

There is nothing inherently valuable about collaboration itself: collaboration is just a vehicle that organizations can use to further their missions and serve their communities. (Sometimes it's easier or more effective to do something by yourself!)

So, because working together–collaborating–can range from informal information-sharing to elaborate, formally structured ventures, each type of collaboration can be located at different points of a continuum. At one end of the continuum, organizations collaborate informally–whether in client services, public policy, or management matters–without written agreements. As collaborative relationships become more intense and more interdependent, they become more formal and structured.

LESS INTERDEPENDENT –› –› –› –› MORE INTERDEPENDENT

Information Sharing Resource Sharing Joint Ventures

LESS FORMAL –› –› –› –› MORE FORMAL

INFORMATION SHARING:
ON THE "LESS INTERDEPENDENT" END OF THE CONTINUUM:

The following examples illustrate how different organizational goals are sought through collaborations on the "less interdependent" end of the continuum:

- *To enhance client services:*
    - Distributing brochures from other agencies in your waiting room
    - Publishing a directory of all HIV/AIDS services available in the community, and distributing the directory through all the agencies
- *To influence public policy:*
    - Faxing a notice to other agencies about pending state legislation on disability insurance or AIDS funding, including the fax numbers of key state legislators
- *To improve organization effectiveness:*
    - Through friendships and informal connections, agencies exchange personnel policies, board policies, information about receptive foundations, etc.

RESOURCE SHARING:
ON THE "SOMEWHAT INTERDEPENDENT" SECTION OF THE CONTINUUM:

- *To enhance client services:*
  - Coordinating service schedules, such as planning which nights at which bars two agencies will do outreach activities
- *To influence public policy:*
  - Convening a meeting of HIV agencies, youth agencies, and pregnancy clinics to influence an elected body (e.g. a School Board decision on high school sex education policies)
- *To improve organization effectiveness:*
  - Joint training program for practical support volunteers
  - Joint negotiation for audits of two organizations with different fiscal year ends to obtain better pricing

JOINT VENTURES:
ON THE "MORE INTERDEPENDENT" SECTION OF THE CONTINUUM:

- *To enhance client services:*
  - Contract for a meals-delivery agency to deliver meals to residents of an AIDS hospice
  - Joint fundraising for and management of a volunteer training program
- *To influence public policy:*
  - Jointly hiring a lobbyist and/or public relations firm to assist in a campaign to influence legislators understanding of needle-exchange programs
- *To improve organization effectiveness:*
  - Joint contracting for office space, lease on office machines, etc.

MERGERS & CONSOLIDATION:
THE "FURTHEST END" OF THE COLLABORATION CONTINUUM

At the "furthest end" of the collaboration continuum is the merger of two or more organizations into a single organization. Mergers and consolidations occur in a variety of ways:

- Merging of a smaller organization into a larger one, becoming a program, division, or site of that organization
- "Spinning off" of a program from one organization to another
- Merging of two or more organizations, creating a new organization

EIGHT MYTHS ABOUT COLLABORATION

1. Collaboration saves money.

Two agencies currently do street outreach to gay men of color in the same city. If they combine their programs in a collaborative venture, they are bound to save money in administrative costs, right? Probably not. Especially in the first few years, even if the amount of work done stays the same, costs are almost bound to increase. This is because the time spent coordinating systems, integrating information reporting, and planning ways to jointly do what each did separately before are all new administrative burdens. It still may be a good idea to combine programs to reduce duplication, to increase the geographic reach to clients, etc. but cost savings is not likely to be a benefit of collaboration in the short-term.*

2. Collaboration is always good.

Collaboration is good ONLY when the benefits outweigh the costs. Benefits can include increased good will, smoother working relationships, more knowledge about another agency, enhanced services to clients or reduced overhead. If you're not confident that your objectives are worth the time, money and energy to be invested, the collaboration may need to be restructured or even abandoned. Sometimes a project works best if it is done by one agency.

3. We should start collaborating.

Chances are, your group is *already* collaborating in many ways quite successfully. Collaborations exist along a broad continuum, and some of your joint projects and networks are collaborations – you just may not have used the word "collaboration."

4. The parties to a collaboration must have equal power.

It is rare to find collaborative partners with equal resources, skills, experience, etc. What is important is to deal constructively with the issues of power in a collaborative relationship. Often the fact that organizations have different competencies and powers is what allows them to join forces in such a way that the whole is greater than the sum of the parts.

5. Collaborations must have written agreements.

The Scarecrow had brains and the Lion had courage before the Wizard of Oz gave them their written symbols. So too with collaborations. Many collaborations are sealed, and function beautifully, on the basis of handshakes and phone calls. All things being equal, writing agreements down tends to help, but it doesn't mean you aren't collaborating with another agency if you don't have a piece of paper.

6. A written agreement is a guarantee against any problems.

On the other hand, just because you have a piece of paper doesn't mean the collaboration will succeed. A Memorandum of Understanding (MOU) may outline agreements which are vital and productive, or may not be worth the paper it is printed on; it all depends on the strength of the commitments that are described on the paper, and the degree of trust and respect between the parties.

* A study of two multi-year collaborations in California found that administrative costs increased from 10% of gross costs to 18% of gross costs with no increase in the amount of services offered. Certain quality improvements were gained though sponsors had mixed opinions about whether these offset the increase in costs.

7. The main reason to collaborate is because funders want to fund collaborations.

Nearly everyone has had the experience of trying to make a collaboration work because a funder has encouraged it. Sometimes a funder may have such a strong hand in a particular setting that its desire to see agencies collaborate prevails, in the short term. Ultimately, collaborations work when the reasons are intrinsic to the goals of the organizations, and collaborations won't work if they're based only on seeking funding

8. If you try hard enough, you can make any collaboration work.

Unfortunately, the experience of organizations across the country tells us that not all collaborations work. It may be that the strategic match is not right. It may be that issues of accountability were never resolved. Changes in key staff or board members may make it impossible for previously smooth working relationships to continue. At some point, the most constructive action may be to recognize when a collaborative project is not working and to end it before more resources are wasted, or before more damage is done to the relationship.

COLLABORATION – THE FUNDER'S PERSPECTIVE

Michael Seltzer, a founder and long-time executive director of Funders Concerned About AIDS, is now a program officer at the Ford Foundation. Michael noted, "We are in a time of deep, profound cutbacks, with growing concern about the impact this is going to have for our many constituencies." While reluctant to generalize about funders as a group, he says, "Grantors will continue to look for ways to enhance the capacities of grantees," and this will translate into ongoing interest in increasing the impact and leverage of individual organizations, including mergers, strategic alliances and collaborations.

Michael goes on to say that funders are learning about how to play a constructive role. He "would like to think" that public funders and private foundations are learning from the mixed experience of recent years that they cannot successfully force mergers or collaborations. Still, he is convinced grantors will continue to provide grants for collaborative activities and to initiate such work.

2. The Fundamentals of Collaboration

- It's About Outcomes
  - Four Rules for Successful Collaboration
  - Using the Four Rules to Assess Ongoing Relationships
  - Voice of Experience: "Keep the Focus on the Clients"

- It's About Relationships
  - Five Tips on Negotiating Collaborative Relationships
  - Voice of Experience: "Don't Take It Personally"

- It's About Power
  - A special note for the smaller agency in a collaboration
  - A special note to the larger, stronger agency
  - Voice of Experience: "It Just Takes Time"

In this section three dimensions of collaboration are addressed: outcomes (choosing and designing collaborations), relationships (maintaining and managing collaborations), and power (the often unspoken truth about collaborations). The Four Rules for Successful Collaboration sum it all up.

IT'S ABOUT OUTCOMES

While many collaborations succeed, many other collaborations flounder, disintegrate, or exasperate their partners. Through work with both successful and unsuccessful collaborations, four fundamental principles, which we call the "rules for successful collaboration," emerge. If one of these rules is broken (and stays broken), a collaboration is likely to fail sooner or later. On the other hand, collaborative projects launched with attention to each of these rules have a strong chance of success.

The Four Rules for Successful Collaboration can be used to help in the planning stages of a project, to set the stage for success. They can also be used mid-stream to help "diagnose" a problem situation, to check progress or to get reoriented.

The Four Rules for Successful Collaboration

1. **The scope of the collaborative project is clearly defined.**

   What, exactly, do you want to accomplish together? For example, you may start with wanting to improve outreach efforts to youth in a particular neighborhood. What activities will be undertaken? And how will you know if outreach efforts have improved? As specifically as possible, describe the activities and the standards by which you will measure both activities and outcomes.

2. **Each partner knows how the collaboration will advance the interests of its organization and clients.**

   Beyond the common goals, what does each party want? Community organizers know that to make a coalition work, self-interest plays a critical role. One director may be worried about her organization's financial health, another director may want access to new services, another may see working together as a way to gain power in the political process. Whatever the personal goals are of individual leaders or specific interests of individual organizations, it helps to be honest about them so that no important agendas remain "hidden." In addition to discussing what each party wants, it may also be important to address each party's fears and concerns.

3. **Roles and responsibilities have been defined; mechanisms for communication and joint accountability are in place.**

   What can each party give? Even among "small" agencies, each with the same or similar mission and clientele, there will be differences in financial stability, management capacity, facilities, board leadership, access to political power, etc. What resources is each party *able* to give, and what is each party *willing* to give to support the joint effort? (Collectively these resources must match the requirements of the project scope discussed in Rule 1. If they do not, either the scope is too broad, or you have the wrong mix of organizations at the table.) Beyond "who will do what by when?," how will you hold yourselves accountable? Regular meetings, financial incentives/penalties related to performance, other?

4. **The relationship "works:" there is enough trust and respect among the key players to support the level of risk and interdependence involved in the project.**

   The most difficult aspect of collaborations, and the least concrete, is the relationship between the partners. A low intensity project such as sharing information on service schedules does not involve "high stakes" and therefore requires less trust between partners. However, in a joint service contract the level of trust and the respect between partners is the intangible element that will either make or break the project: no contract can spell out every possible eventuality. Are we able to communicate effectively? Are the right people involved? Can the relationship among the participants support the kind of honest talk and genuine listening required to work together successfully?

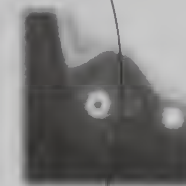
The Four Rules for Successful Collaboration

1. **The scope of the collaborative project is clearly defined.**
2. **Each partner knows how the collaboration will advance the interests of its organization and clients.**
3. **Roles and responsibilities have been defined; mechanisms for communication and joint accountability are in place.**
4. **The relationship "works": trust and respect among the key players are sufficient to support the level of risk and interdependence involved in the project.**

Worksheet

Four Rules for Successful Collaboration Checklist

Four Rules for Successful Collaboration Checklist	To what degree are we satisfied that... LESS MORE	Action or changes to be considered/discussed with partner(s):
1. The scope of project is clear: • Benefit to clients is clear • Overall goals and objectives defined	 1 2 3 4 5 1 2 3 4 5	
2. Benefits to us are clear: • Organizational benefits sought • Individual needs/interests	 1 2 3 4 5 1 2 3 4 5	
3. Responsibility/accountability is clear: • Who is going to do what by when • Mechanism for monitoring and for correcting/adjusting plans is in place	 1 2 3 4 5 1 2 3 4 5	
4. We can depend on each other • The appropriate people are involved • There is enough trust and respect for this project to work	 1 2 3 4 5 1 2 3 4 5	



DATELINE: Collaborationtown, U.S.A. Several months ago, in a meeting about another subject, program staff from the Palm Tree Health Center and the Executive Director of the Aspen AIDS Service Organization agreed to distribute each other's brochures to clients visiting their respective offices.

In a good faith attempt to "be collaborative," a few staff members at the Aspen ASO take referrals for the Palm Center, call to get more brochures when their supply runs out and call whenever there is a question about the range of services offered at the Palm Center. But the Palm Tree Health Center doesn't reciprocate. A few of the staff at the Aspen office come to resent this "sharing" of information. They bring their concerns to the Executive Director as "another example of the Palm Center's lack of respect for our work and our staff."

The Executive Director of Aspen wonders, "How can we possibly have a problem with such a simple collaborative project?!"

* * * * * * * * * *

Even without knowing more than the information in these brief paragraphs, we can use the 4 Rules to ask a few key questions.

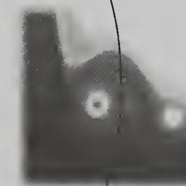
1. Did the "scope" of the agreement include the kind of follow-up provided by Aspen staff? The agreement was probably not written down, so the people at the original meeting may need to have a conversation to clear this one up.

2. What were the benefits sought by each group? Does Aspen staff expect a much closer working relationship than "exchanging brochures" implied to Palm Center? Is Palm hoping to gain access to a new population through Aspen? Are each group's objectives clear to themselves and each other?

3. Responsibilities, accountability: who *was* supposed to do what by when? Again, the original deal makers may need to have another conversation.

4. Will this relationship work? How the two organizations handle this snag in their relationship will have an impact on whether they are able to move on. . . or not. If key staff can have an honest discussion with each other, acknowledge their own parts in the misunderstanding and re-negotiate the terms of their arrangement, they are likely to build trust through this mini-crisis.

Do these rules apply even in informal collaboration projects? Yes! Unfortunately, the opportunity for misunderstanding and wasted effort is always present!



VOICE OF EXPERIENCE: "KEEP THE FOCUS ON THE CLIENTS"

Earl Fowlkes is the new Executive Director of Damien Ministries in Washington, D.C. Damien provides a number of services including a food bank, housing and care for people with AIDS coming out of jail on medical parole, and many types of support groups for both people living with HIV and their caregivers.

The organization has several very strong collaborative relationships. Damien Ministries has run a highly successful weekend retreat program for several years with another group. They subcontract for specific services to be provided at their residence with a local hospice organization. And Damien is staffed mostly by individuals from religious orders and communities — a collaboration which provides supervised field work and service opportunities for interns and provides much-needed staff to the program.

However, it is a recent *failed* project which highlights all that can go wrong with a collaboration. Earl is still working to get things back on track.

“Ryan White fever came around and we all came together, doing a lot of talking and they funded us to create a coalition. Now three of the other four (agencies) have gone under! They needed to be direct and honest (about their limitations and difficulties). It’s not a sin to say ‘I need this.’”

“One thing that is true in AIDS work, when agencies have financial difficulties they won’t mention it. This explains in retrospect why they were fighting over money.”

What advice do you have for other collaborating agencies?

Earl says that in addition to honest talk, conducting a needs assessment for the collaboration could have helped the group to realize they did not have had the right agencies at the table in the first place.

“As the money dwindles, the focus has to be on the clients and we tend to forget this. Establish goals and objectives right up front; what the needs are and how are we going to meet them? *Then* bring in agencies that are somewhat sound, people who can bring something to the table.”

IT'S ABOUT RELATIONSHIPS

Jazz bands and collaborations share this common feature: two or more people are engaged in a joint effort. Musicians learn basic technique and move on to develop an ability to blend their efforts with those of others into a single performance. So too must collaborators learn the technical skills of planning and negotiating collaborative projects and build toward mastery of managing successful collaborative relationships.

Just as a jazz band is judged not by how well its members get along, but by the music they produce (although how well they get along will have an impact on their music!), collaboration is measured by the effectiveness of the relationship. The bottom line is increased accomplishment of an organization's mission.

As with music, practice helps. In the corporate world, effectiveness is measured by profitability. A major business consulting firm (Booz-Allen & Hamilton) found that as international corporations gained experience with strategic alliances, their profitability steadily increased. In the world of AIDS service organizations, effectiveness is measured in terms of preventing infection and delivering high quality, cost-effective services to people living with HIV and AIDS. Our experience indicates the same principle holds true for ASOs: as organizations gain experience with managing collaborative relationships they are increasingly able to get the most done.

So don't be surprised if your early efforts get chalked up as "learning experiences." Every manager and volunteer leader learns through experience. However, you can also learn from the experience of others. The following guides to developing successful relationships have been put together after lots of experience, both successful and not!

The first three rules of collaboration (scope, benefits, responsibilities) require solid planning. The fourth rule, "a relationship which works," requires honest talk and skillful negotiation. The following five tips on negotiation will help achieve success in this area.

5 TIPS ON NEGOTIATING COLLABORATIVE RELATIONSHIPS*

Even with good planning, sometimes agencies still feel that they have "been taken advantage of," or "cut a bad deal." In a collaboration, people come together because they share certain goals and needs with people from one or more other organizations. But when negotiating an agreement, the most important thing to remember is that in *every* collaboration, each party also must attend to its *own* goals and needs. As Earl Fowlkes from Damien Ministries in Washington, D.C. says: "It's not a sin to say, 'I need <u>this</u>.'"

* Several of the ideas in this section are adapted from *Getting to Yes,* by Roger Fisher and Wiliam Ury . See "Where to Turn for More Help" in the back for full reference.

Five Tips on Negotiating Collaborative Relationships

1. Prepare! Think through what your goals are worth to "your side." If you do not know what they are worth to you, it is hard to know if you have a good deal or a bad deal.
2. Be as creative as possible in maximizing mutual gain from the potential collaborative project.
3. Focus on interests, not positions.
4. Separate the people from the problem.
5. Be clear, and consistent, about who represents the organization in negotiations <u>and</u> about the <u>internal</u> process for delegating this authority.

Negotiating Tip #1

Prepare! Think through what your goals are worth to "your side." If you don't know what they're worth to you, it's hard to know if you have a good deal or a bad deal.

After you have begun to answer the questions involved in the first rule of collaborations (the scope of the project), and the second rule of collaborations (the benefits you seek), the next step is to think about what you are willing to give or invest to achieve these benefits.

> "We want access to the clinical services provided by the AIDS Center, and we are willing to provide outreach and transportation efforts to increase access by our populations. However, it is also essential to us that we get full cost reimbursement and that the planning process include both boards."

One way to think about what your goals are worth to you is to consider what you will do if you don't reach agreement. What is the best alternative?

In the above case, is access to the clinical services "worth it" even if we don't get full cost reimbursement, or the planning process is constrained? How else might we get similar access to these services? What would it take to get similar access at the local hospital? Given our alternatives, what is *this collaborative option* worth to us?

Negotiating Tip #2

Be as creative as possible in maximizing mutual gain from the potential collaborative project.

There is an old story about a brother and a sister who each want the only orange left in the house. The brother wants the orange in order to grate the peel for a cake, the sister wants to eat the fruit. In a typical situation, if they did not tell each other <u>why</u> they wanted the orange, they might fight over it or flip a coin so that one gets full use of the orange. If they were feeling cooperative they might split the orange

in half, so that each gets use of half the orange. However, if they talk about their purposes more precisely, they **both** get **full** use of the orange, almost as if there were two complete oranges, one for each purpose.

Many of the informal collaboration opportunities discussed previously emerge from this kind of open discussion. The Executive Director of POCAAN in Seattle (see case study next page) has a monthly meeting with seven directors of other large agencies. From this regular meeting, many creative resource-sharing ideas have emerged, including one way to *increase* political leverage while *decreasing* the amount of time each has to spend at various meetings.

By agreeing on certain public policy goals, and agreeing on the meetings and forums where their views need to be represented, each individual takes a turn representing the group. This way all the directors are "present" through the collaboration's representative; not only can they (in effect) be in two places at one time, they speak with a louder voice because it is amplified by the number of groups in their collaboration.

Negotiating Tip #3

Focus on interests, not positions.

In the story about the orange above, both the brother and sister started out with the "position" that they wanted the whole orange. These positions were obviously not both possible. As long as they fought to defend their positions ("you got the orange last time, so I deserve it this time; I need the orange more than you do..."), only one could win. However, as soon as they began to talk about *why* they wanted the orange, their "*interests*" in the orange, they could immediately see a new solution better than either of their original positions.

Whenever an impasse appears in a negotiation, or in the ongoing management of a collaboration, stop and try to understand what the interests are that are leading to each side's position. Then it will be possible to look for new ways out of the place where you got stuck.

DATELINE: Collaborationville, U.S.A. "What do we *really* want?"

Let's say a smaller, minority organization, AIDS Action, and a larger, mostly white organization, AIDS Center, collaborate to better serve the minority population through increasing access to established services at the historically white organization. They both declare their preference for having the case manager on their own staff roster. If they don't explore this situation, one side will "win" and the other will "lose," if they go forward with the collaboration. Either the case manager will be on the roster of one organization or the other.

Suppose the reason the smaller organization wants the person on staff is to collect some of the eligible indirect charges to help with overhead costs associated with the collaborative project. The larger organization wants to ensure adequate supervision so that integration with the current services happens smoothly, but is less concerned about overhead costs. A number of alternatives then emerge: the case manager could be on the roster of *either* organization *as long as* AIDS Action receives some help with indirect costs and AIDS Center achieves adequate coordination of the case manager's activities with its current services. If they both understand their underlying interests, it is clear that both organizations can be completely satisfied, and neither has to "lose."

Negotiating Tip #4

Separate the people from the problem.

The leaders of most AIDS Service Organizations already know of their many potential collaborators. And they are likely to continue to interact with these people over the years to come, in one organizational setting or another. Thus one goal we all have is to keep communication open and to build working relationships.

In the middle of a joint project though, it can seem as if your *only* problems are the other <u>people.</u> It is important to remember why you are working with the others in the first place: to improve the accomplishment of your organization's mission. Thus, when partners behave in ways you don't like, or don't seem to understand the situation from your perspective, you have two choices: you can talk louder, or you can listen harder.

The ability to see the situation as the other side sees it, as difficult as it may be, is one of the most important skills a negotiator can possess. For then, you can begin to solve the problem as the other side sees it, and discover new solutions which will serve you both.

Negotiating Tip #5

Be clear, and consistent, about who represents the organization in negotiations and about the internal process for delegating this authority.

One of the best ways to show <u>disrespect</u> to your prospective collaborative partner is to repeatedly send different people to meetings, or even worse, send people who do not know enough or do not have enough authority to represent the organization's interests. It is <u>not</u> the case that the executive director is the only staff person who can negotiate with other organizations. It <u>is</u> the case that without appropriate authority, no representative can conduct meaningful negotiations on behalf of an organization.

A corollary of this tip is that each side's *internal* decision making process must be effective enough to be able to speak with "one voice" to your prospective collaboration partners. Have you organized a way to get input from program staff who will be affected? Is there a board committee or group of individuals who are likely to care deeply, and/or are in a position to block a potential collaborative project? Are senior managers in agreement about what the organization's interests are, and about the extent and limits of authority delegated to representatives meeting with other organizations? These questions must be answered to effectively speak with one voice.

VOICE OF EXPERIENCE: "DON'T TAKE IT PERSONALLY"

Lupe Lopez' job title might just as well be "Executive Collaborator." Two years ago Lupe was recruited away from a job in San Diego to succeed the founding director of People of Color Against AIDS Network in Seattle, WA. As the Executive Director of a statewide organization, with a budget of $1.7 million from 40 funding sources and no fewer than ten active community organizing coalitions, Lupe spends an enormous amount of her time managing "internal" collaborations among POCAAN coalitions, and building coalitions with other organizations in the community on behalf of POCAAN and its member coalitions.

In Seattle in 1987, the vast majority of recorded AIDS cases were still among gay, white men. However, a few leaders in communities of color could see that the epidemic was headed their way. POCAAN initiated a multi-pronged strategy to prevent the spread of HIV as well as to help those who become infected.

Lupe notes, "There is a lot of distrust among people of color of the mainstream institutions, among people who grew up in this country as well as those from other countries. This organization was founded to get the word out that the risk was real, AIDS is not just a 'gay, white' disease."

"We focus on coordinating outreach, education and community organizing among the different groups. But we don't have the resources to do everything. We have access to the population and we work to make services at mainstream institutions available to our populations."

What makes collaboration work? Lupe says, "I've learned the person at the helm has to be able to play a neutral role, you can't take things personally if you want to get people to work together."

"This field is very personal. It's impossible to separate yourself from the work. Once trust is lost between people it's hard to rebuild. In Seattle, we have now created an environment where we agree to disagree, if leaders at one organization have something to say, they call directly, we don't hear about problems second hand. We are clear about roles and treat each other as equals."

In discussing the successful collaborative relationships POCAAN has built, Lupe also emphasizes the importance of a strong and committed board and executive director, the value of careful planning and finally the need to formalize agreements and procedures.

"We don't have to be mainstream, but we have to grow up and write things down. Our by-laws, our agreements with coalitions and our accounting practices are now on paper. When we have to revise them, we do it together."

It's About Power

The reason groups collaborate is to increase their collective "power"—their ability to get things done. Yet this is also one of the most difficult areas in which to find and maintain balance. (One therapist, when asked what couples fight about, said "Money, sex and power... but mostly it's about power.")

In most collaborations there is an imbalance of power. One agency is simply bigger, stronger, has more money or more political clout, or appears to stand on higher moral ground. The negotiation tips will help with power imbalances, but we include a few more thoughts on this difficult area.

What's the right approach to this imbalance of power? First, let's talk about the *wrong* approach. It would be a mistake to pretend that the imbalance doesn't exist. It would also be a mistake to insist on making power equal (one collaborative effort between two AIDS agencies broke down when one insisted on waiting until its cash reserve was equal to the other's). And, at the same time, it would be a mistake to let the power relationship dominate the collaborative relationship. Below are some thoughts for the smaller agency with fewer resources, as well as some thoughts for the bigger, stronger agency.

A SPECIAL NOTE FOR THE SMALLER AGENCY IN A COLLABORATION:

It's tough, isn't it? In a collaboration with a bigger agency, it's easy to feel aggravated by their greater resources, threatened by having a weaker negotiating position, and irritated by the way they make assumptions about how things are going to get done. It's tough to do the same kind of homework a project requires, but with fewer resources. It's especially tough to know whether you're making too much of a small thing, or whether you're being taken advantage of, or whether they are really as committed to the project as you are.

When they say, "We'll handle the money; we're already set up to do it," are they just making a helpful offer or will they end up being in charge of everything as a result? Is it okay for them to send their program director to the collaborative meetings when you send your executive director?

Regardless of the motives that bring the larger agency into the collaboration, try to stay clear about your own. Maybe the other agency is a large, mainstream AIDS agency that you suspect wants to collaborate with you mainly to increase their minority service statistics. Consider the following principles for your "stance" in the relationship:

a. **Be straightforward about your objectives.** If you want to do program work as a subcontractor, make an arrangement that reflects this. If you want to share responsibility for fiscal management, or if you want to gain experience in this area, say so.

b. **Keep your eyes on your *own* objectives.** If your objective is to get more resources to your clients as a result of collaborating with the larger agency, *that's* the measurer of whether the collaboration is worthwhile. Maybe the other agency is a large, multi-service community center, without the deep commitment to AIDS that you consider fundamental. Keep your eyes on what brings *you* to the collaboration: perhaps easier access to other social services for your clients, and perhaps, over the long term, the opportunity to educate the leadership of the community center about AIDS, sexual diversity, or other matters.

c. **Don't forget what you bring to the table.** Don't for a minute forget what *you* bring to the collaboration. Often, a smaller agency has access to a particular population, or staff and board members with particular expertise and backgrounds. Just because a larger agency may be more developed in some ways does not mean that your contribution to a particular project is not just as valuable and critical to the success of the effort.

d. **Learn.** Make it a priority to find opportunities to learn from the other agency, whether about client needs of an unfamiliar population, a different way for a workteam to work together, or how individuals maintain their personal commitments to the work.

A SPECIAL NOTE TO THE LARGER, STRONGER AGENCY:

It's tough, isn't it? Sometimes it feels as if *you're* doing all the work, and they're "just along for the ride." Of course, you realize that you have more resources, but sometimes it seems as if they are simply disorganized. They seem to get hung up over little things, like who's going to pay for some small, up-front expenses. They assume that just because you're big, you have no financial worries. And sometimes they seem to have a "more politically correct than thou" attitude, when your commitment to clients is just as deep and just as strong.

At the same time, you are in this collaborative arrangement for a reason: to expand services to the community, to broaden fundraising opportunities, to learn. Consider the following principles for your "stance" in the relationship:

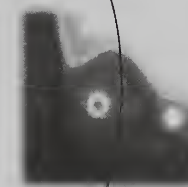
a. **Be straightforward about your objectives.** If one of your goals is to include minority representation to be more competitive for funding or political influence, say so. Similarly, if you are only looking for a limited partnership, perhaps one program or initiative, make those limitations clear. It is far better to start small and build than it is to build up expectations in a partner and then pull back.

b. **Be generous with money.** A given dollar figure, such as $5,000, may mean much more to the other agency than to yours. It may actually cost you more to do a certain task than it does them (perhaps because your salaries or overhead are higher), but consider allocating joint funds at the same rate. Establishing a long term strategic relationship with the smaller agency may even be worth "losing,"–*investing*–money in the collaboration.

c. **Be generous with your time, expertise, and verbal support.** Not only will it help the collaborative project, but the individuals at the other agency will grow professionally and be able to contribute more at their current *and* future jobs towards fighting the epidemic.

d. **Learn.** Make it a priority to find opportunities to learn from the other agency, whether about client needs of an unfamiliar population, a different way for a workteam to work together, or how individuals maintain their personal commitments to the work.

Remember: partnerships work best when both agencies are strong. Our communities need both big and small agencies, both general and population-specific services, both direct services to people with HIV *and* prevention work, both anonymous and intimate settings. Because you're bigger, you have a greater responsibility towards building the partnerships that will serve our communities. Don't let yourselves be exploited–you'll only end up resentful–but consider what role you can play and what investment you can afford to make.



VOICE OF EXPERIENCE: "BE PREPARED FOR A CLASH OF CORPORATE CULTURES"

Papa Ola Lokahi is a statewide organization in Hawaii which focuses on a wide range of service needs for its native Hawaiian clients. In the past few years Papa Ola Lokahi has initiated a number of collaborative relationships with other service providers, including established AIDS service organizations.

Pua Aiu, the Research Officer and director of POL's AIDS Case Management Project, says that differences in corporate cultures have made collaboration challenging.

"We have done focus groups with our clients and found that they don't feel really comfortable in an environment (at the other organizations) which has historically had a white, gay male focus. But it's a matter of all of us making adjustments so clients can get the best services possible. Our clients understand this too.

Still, she says "this is the best route because AIDS clients need a lot of services; we could have gone with our own office but (the other organizations) are already set up, have access to a wide range of services and have better staff support. In the long run, the benefits far outweigh the costs.

But that isn't the only reason Pua pursues these collaborations. "I have a problem with all these small minority organizations. It is important for the majority culture to begin to change. My goal is to see their management turn a different color."

As for advice to other collaborators, Pua says "Push for what is best for clients, you need to understand up front exactly what you're going to do and expect that corporate cultures will clash. I don't take things for granted and I don't take things personally. In fact, I like all of the people we do collaborations with, but like family, we have differences in how we should keep our house. I think we need to focus on the goal of getting clients into a place that provides the services they need. As for other service providers, if we keep being in their faces, they will change, it just takes time.

3. Strategies for Specific Situations

- **Informal Collaboration**
- **Collaborative Fundraising**
- **Fiscal Agents and Fiscal Sponsorship**
- **What is an MOU? MOA? How Do You Write One?**
- **Consultants to Collaborations**

This section provides a collection of ideas which can help with some common types of collaborative projects. First, we include a brief discussion of the informal collaborations that many organizations are involved in, but may not consider "collaboration." Collaborations may be more familiar than is immediately obvious. And, informal relationships often provide the basis for more involved projects. Following that discussion are frameworks, samples, and tips for collaborative fundraising, fiscal sponsorships, Memoranda of Understanding (MOUs), and working with consultants.

INFORMAL COLLABORATION

Sometimes the simplest, highest-impact collaborations are so natural they hardly feel like "collaboration." Imagine:

- One AIDS hospice makes all its volunteer training sessions open to volunteers from two other hospices, one AIDS-oriented and the other more general. Each time they schedule a session, the volunteer director simply calls the other two agencies: "We're having another volunteer training session on Thursday the 28th. Do you have anyone you would like to send to it? Could you bring the refreshments this time?"

- An AIDS activist and an AIDS caseworker found themselves standing side by side at a street fair distributing materials to the public. "This is crazy," said one of them. "Why don't you go home and I'll pass out your materials, and next month you can go to the street fair on the East side and pass out our stuff."

- Two acquaintances found out they were both board presidents of AIDS organizations, and decided to have lunch. The next day, one left the following voice mail message to the other: "Great lunch. I agree 100% that our two Personnel Committees should exchange drafts of the new personnel policies. And while we're at it, what about splitting the cost of a compensation consultant to help us both assess our salary levels?"

What informal collaborations are you already engaged in? Make a list of several examples and share it with others in your organization. This will help everyone realize that "collaboration" doesn't have to be complicated or formal, and will spark ideas about new collaborations. Write up a few of these collaborations as "mini-stories" and include them in your grant applications, reports to the board, and staff meetings.

Worksheet

Current Collaboration

Project #	Who in our organization is involved?	What other organization(s) is (are) involved?	Have we satisfied the 4 Rules of Collaboration for this project?	What improve-ments might we make?
1.				
2.				
3.				
4.				

STRATEGIES FOR SPECIFIC SITUATIONS

COLLABORATIVE FUNDRAISING

The most common forms of collaborative fundraising among HIV/AIDS service organizations are:

- **Community-wide AIDS fundraising calendar**

  Collecting information about fundraising events can help agencies avoid "bunching up" events. In some cities where several agencies may be planning capital campaigns for buildings, information sharing can help them avoid having too many solicitations to the same few individuals at the same time.

Idea Find one person, such as someone in the County AIDS Office, or an AIDS agency development director, who will collect calendar information and fax it monthly to everyone.

- **Joint special events**

  Some special events are coordinated and managed by a collaborative committee, where "member" agencies contribute time and resources towards making the event a success, and from which funds raised are distributed to member agencies.

Idea Draft and sign an MOU (see section on MOUs) that clearly assigns responsibilities to the various agencies, and establishes the rules for how funds will be distributed.

- **Joint submission of grant proposals**

  Collaborative projects often have a first phase of collaborative submission of grant proposals to foundations and corporations for joint or collaborative projects.

Idea Consider sending the proposals on paper without a letterhead, accompanied by letters of support from the collaborative members, each on their own letterhead.

- **Collaboration/partnership with a business, such as a local restaurant or retailer to put on a fundraising event**

Idea Send a confirming letter to the business, stating the agreement as you understand it, including responsibilities for costs of the event, who will plan the program, and how funds will be collected and distributed. Make it easy for the business to work with you, so they'll look forward to repeating the event.

- **Partnerships through an intermediary fundraising organization, such as an AIDS Walk, bike-a-thon event, or other fundraiser**

Idea Groups such as these may begin as one-time partnerships, but can grow into major, ongoing fundraising organizations. Make a strategic choice about developing such a group or just staying in touch.

COLLABORATIVE FUNDRAISING EVENTS:

When asked about examples of collaborative fundraising events, a well known AIDS fundraiser remarked (provided he was quoted anonymously): "Off the top of my head, I can't think of any that made money."

A common downfall of joint fundraising events is every organization believing that the other organizations are the ones who will make the event successful. Take the same care or more with a collaborative event as with one you are doing yourselves.

FISCAL AGENTS AND FISCAL SPONSORSHIP

A special format that collaborations sometimes use is fiscal sponsorship, or having one agency act as a fiscal agent for the collaboration or for another agency. Examples of the most common situations are:

- Two or more organizations jointly submit a contract proposal for government or foundation funding, with one agency acting as the lead agency (or fiscal agent) for the contract.
- A new organization wants to begin operations, including receiving tax deductible donations, immediately, before their incorporation and tax exemption comes through. They decide to begin work under the auspices of an established organization, which acts as their fiscal agent or sponsor.
- Two or more organizations decide to work together on a benefit film showing. One organization acts as the fiscal agent, receiving the funds and then distributing them as agreed.

Now, for more on each situation:

Jointly held contract: Two organizations–let's call them AB Agency and the CD Center–come together to propose a joint contract with the County AIDS Department. One organization–let's say AB Agency–acts as the "lead agency," signing the contract and receiving the funds. The two organizations develop an MOU (Memorandum of Understanding) that outlines how they will work together on the contract, and a copy of the MOU is included in the proposal to the county.

As outlined in the MOU, the CD Center will receive $200/unit of service in the contract, up to 315 units. As the CD Center completes those units of service, they send an invoice to AB Agency for payment. AB Agency then invoices the County AIDS Department and when reimbursed, passes along the payment to the CD Center. As compensation for handling the accounting and the liability, AB Agency will receive a higher portion of the indirect costs in the contract.

New organization: Suppose that a new AIDS organization in the local community–let's call it Maple HIV Services–asks an established organization such as the AIDS Foundation–to act as its fiscal sponsor. The AIDS Foundation is confident that the activities of Maple HIV Services are tax-exempt in nature, and "lends" its 501(c)(3) status to the new group. Donors and grantmakers make out their checks to "Maple HIV Services, a project of the AIDS Foundation," and the checks are deposited into bank accounts of the AIDS Foundation. As a result, the new Maple HIV Services can begin receiving grants and tax deductible donations right away.

Joint fundraising event: Two organizations agree to open up a special checking account under the name "Spring Film Benefit," but using the tax ID number of the fiscal agent. They also agree that each will put up one-half the cost of the theater rental and $1,000 each for pre-event costs, and that the net income will be split 50/50 after the event. The fiscal agent agrees to handle the receipts and disbursements from the special checking account. The partners must agree on how they will handle a variety of financial affairs. For example, how will credit card payments be handled? How many "free" tickets can each group have?

Of central concern is that the fiscal sponsor (and its board) bears the legal responsibility for actions of the collaboration or the fiscal client. As a result, fiscal sponsors usually seek some measure of accountability, such as regular financial and activity reports. On the other side, fiscal clients or partners want regular reports to ensure that their funds are being held safely and have not been "borrowed" by the fiscal sponsor.

Tip Fiscal sponsorship can cause legal problems for either or both sides. Regardless of how the relationship is defined, a written agreement should be drawn up that details the responsibilities of each side. A comprehensive guide to fiscal sponsorship is Gregory Colvin's *Fiscal Sponsorship: Six Ways to Do It Right*, available through Study Center Press. (See "Where to turn for more help" in the back of this manual for information on ordering.)

WHAT IS AN MOU? MOA? HOW DO YOU WRITE ONE?

An MOU (Memorandum of Understanding) or MOA (Memorandum of Agreement) is simply a statement of what you each understand you have agreed to do. When writing one, focus on stating your agreement clearly, rather than on trying to create a legally enforceable document. If there is a matter that you haven't decided yet, go ahead with the MOU but include items that will be resolved later and how they will be resolved. Keep in mind that funders may ask for copies of MOUs.

An MOU is not a guarantee against misunderstandings or bad faith agreements, but it can help prevent problems or conflicts from arising. An MOU should be a reflection of, not a substitute for, ongoing communication and planning.

Following are three examples of MOUs:

A. MOU as a simple confirming letter
B. MOU as documentation for joint contracting with a county health department
C. MOU as a signed agreement between two agencies for joint operation of an ongoing program (a joint venture)

A. MOU as a confirming letter

In this example, an AIDS organization confirms an arrangement with a Community Center.

Carlos Chang
Executive Director
Community Center of East County
1848 Main Street
Conntown, New York

Dear Carlos:

I really feel we got a lot accomplished in our meeting yesterday, and as we agreed, I'm writing up my notes from the meeting to be sure that we're all in agreement about what we decided.

Starting next month, our staff will be able to use one of your offices on Thursdays to see clients. One of our counselors will be there every Thursday from 10 am to 6 pm. Clients who arrive at your office may sit in your lobby until their appointment, and the Community Center receptionist will "buzz" our staff counselor to let them know that a client has arrived.

We will pay the Community Center $125/month, which we will pay on the last day of the month (to help us with our cash flow). For example, we'll pay the November rent on November 30.

You are going to publicize the availability of this service at your location, emphasizing that appointments are necessary, and that appointments must be made through our office. You'll send two copies of any such publicity to me.

If any of this is different from what you understand, please let me know immediately. I think that this arrangement will help make our services more convenient for people with HIV in your neighborhood, and help increase referrals between our two agencies. We look forward to working with you.

Sincerely,

Kathleen Simone
Executive Director
Community AIDS Services

cc: President, Board of Directors, Community Center of East County
President, Board of Directors, Community AIDS Services

B. MOU as documentation for joint contracting with a county health department

In the following MOU, the AB Agency and the CD Center confirm their agreement to jointly contract with the County Health Department to provide services. The AB Agency is acting as the signatory for the master contract, which divides the scope of work and payments between the AB Agency and the CD Center. This MOU is written in "legalese," and focuses on arrangements required by the contract.

Subcontract Memorandum of Understanding between the AB Agency and the CD Center

SECTION 1 – CONTRACTING PARTIES

This agreement entered into on April 22, 1996, by and between the AB Agency and the CD Center, herein called the "SUBCONTRACTOR," for services to be performed under the contract with the San Francisco Department of Public Health AIDS Office, Contract No. HC-6-12345. Now, therefore, the parties herein do mutually agree as follows:

SECTION 2 – SCOPE OF WORK

The SUBCONTRACTOR shall be responsible for the execution of services in a satisfactory and proper manner as determined by the SFDPH AIDS Office in regards to the contract requirements and as defined in the contract named above.

SECTION 3 – TERM OF CONTRACT PERIOD

The above services shall be performed at the locations designated in the Scope of Work exhibit of the above contract, starting July 1, 1996 and ending June 30, 1997.

SECTION 4 – INVOICING & PAYMENT

The maximum dollar obligation of the AB Agency to the CD Center for services performed under the terms of agreement shall not exceed $62,911.00.

The SUBCONTRACTOR will submit an invoice by the tenth working day of each month for reimbursement of the previous month's actual expenditures. Subcontract payments will be made within seven working days of receipt of contract payments from the AIDS Office for the same period.

Subject to contract modification, only expenditures approved by the AIDS Office and put forth in the Subcontract Budgets may be reimbursed. All invoices must be submitted on the SFDPH Invoicing Form.

The Fiscal Monitor for the AB Agency and the contract will be the AB Agency's Fiscal Director, Xavier Young.

SECTION 5 – MONITORING & REPORTING

SUBCONTRACTOR agrees to report on each monthly invoice, the number of units of service delivered in the preceding month for each service mode defined in the contract's Scope of Work.

SUBCONTRACTOR agrees to submit semi-annual reports due January 10, 1996 and July 10, 1997. SUBCONTRACTOR agrees to submit annual monitoring and other materials as required by the AIDS Office, according to schedules listed in the contract or otherwise agreed by the AB Agency and the SUBCONTRACTOR.

SECTION 6 – MODIFICATION IN BUDGET & SCOPE OF WORK

Requests for budget modification must be submitted to the Subcontract Fiscal Monitor on the SFDPH Budget Modification Form and accompanied by a written explanation. Requests for Scope of Work Modifications must be submitted to the Subcontract Fiscal Monitor in writing in the SFDPH Program Narrative format explaining why the original Scope of Work is no longer appropriate. Requests for modifications will be submitted to the AIDS Office and will take effect upon approval by the AIDS Office.

SECTION 7 – SUBCONTRACT COORDINATION

SUBCONTRACTOR agrees to appoint a SUBCONTRACTOR Program Monitor and SUBCONTRACTOR Fiscal Monitor. The SUBCONTRACTOR Program Monitor will attend contract and program coordination meetings. The SUBCONTRACTOR Fiscal Monitor will adhere to the invoice requirements prescribed herein and will respond to all phone inquiries by the AB Agency's Fiscal Monitor within one working day and to all written inquiries within five working days.

SECTION 8 – AMENDMENT & TERMINATION

The parties hereto acknowledge and understand that SUBCONTRACTOR must receive written approval from the AB Agency in order to amend this Subcontract Memorandum of Understanding in any fashion. In the event that either party wishes to terminate this agreement, a 30-day advance notice shall be given.

SECTION 9 – TERMS & CONDITIONS

SUBCONTRACTOR is subject to all terms and conditions placed by the San Francisco Department of Public Health AIDS Office on the AB Agency.

SECTION 10 – CONFIDENTIALITY AND RECORDS MAINTENANCE

SUBCONTRACTOR agrees to maintain adequate records of clients required by the contract and further agrees that information and records obtained in the course of providing services shall be subject to the confidentiality and disclosure provisions of applicable City, County, State and Federal statutes and regulations pursuant thereto.

Approved for the AB Agency:

Approved for the SUBCONTRACTOR:

C. MOU as a signed agreement between two agencies for joint operation of an ongoing program

By contrast, this MOU is written in ordinary language and focuses on the how the relationship will work and the ways in which coordination will take place. In this example, two organizations want to develop and operate a drama-based program for youth that would write and perform short plays focusing on AIDS prevention.

Memorandum of Understanding

This agreement, entered into by the ABC Agency and the XYZ Center, establishes a basis on which the two organizations will jointly develop, seek funding for, and operate a prevention education program.

Program development

1. The two organizations will jointly design the program, obtaining input and assistance from others; each executive director is responsible for ensuring that the program adequately incorporates their respective organization's priorities.

Funding:

2. All proposals for the program will be jointly submitted by the two organizations, with all correspondence with funders signed by both executive directors.
3. A copy of this MOU will accompany proposals for funding.

Staffing:

4. The Program Director will be hired and supervised jointly by the executive directors of the two organizations.
5. Staff will legally be employees of the XYZ Center and subject to its personnel policies. Employee evaluations will be conducted jointly by the executive directors of both organizations, and signed by the executive director of the XYZ Center.
6. If additional staff is hired for the program, that staff will be hired by the Program Director with the approval of both executive directors, and will report to the Program Director.
7. Desk space, office supplies, telephone and other office support will be provided to program staff by both organizations.
8. The Program Director will be located three days per week at the ABC Agency and two days per week at the XYZ Center.

Finance:

9. Grant funds will be received by the XYZ Center.
10. The XYZ Center will provide monthly financial reports on the program to the ABC Agency within four weeks of the end of each month.
11. The XYZ Center is responsible for financial reports to funders.

12. The ABC Agency may incur expenses as indicated in the approved program budget, and will invoice the XYZ Center for those expenses monthly, within two weeks of the end of each month. The XYZ Center will reimburse those expenses within two weeks of receiving the invoices.
13. Neither organization may incur expenses related to this project of $500 or more without notifying the other organization in writing and obtaining approval in advance.
14. Any capital equipment (such as the planned laptop computer) that is purchased by the program will be held on the books of the XYZ Center. If the program is terminated, the XYZ Center will have the first option of purchasing the equipment by paying 50% of the initial cost of the item(s) to the ABC Agency. The ABC Agency will have the second option of purchasing the equipment from XYZ Center at 45% of the initial cost to the XYZ Center, etc.

<u>Public relations:</u>

15. At a later time, but within the next two months, the two organizations will agree on a name for the program. Letterhead, business cards, brochures and other materials will be developed for the program, and will include wording such as "Jointly managed by the ABC Agency and the XYZ Center," or "A collaborative project of the XYZ Center and the ABC Agency." Mention of the program in either organization's materials, such as newsletters or annual reports, will include similar wording.
16. Written materials will be jointly copyrighted by the two organizations.

<u>Length of this agreement</u>:

17. This agreement will be in place until one year after awarding of grant funds.
18. This agreement will be reviewed after six months by the two organizations to propose changes or additions.
19. Either organization can choose to leave the agreement and discontinue sponsorship of the program with the written approval of the other.
20. For the term of this agreement, both organizations agree not to start or participate in starting a theater group around AIDS prevention to youth in the Tri-Cities area without the express consent of the other.

Signed:

______________________	______________________
Board President	Board President
ABC Agency	XYZ Center
Date: ______________	Date: ______________

CONSULTANTS TO COLLABORATIONS

While many collaborations rely entirely on the staff, board and volunteers of the agencies involved, other collaborations find it helpful to contract with consultants. In many respects, the relationship between the collaboration and the consultant is *itself* a collaborative relationship. The Four Rules for Successful Collaborations apply: you need to clearly define the scope of the project and the benefits expected for each party, agree on responsibilities and mechanisms for accountability and determine if the relationship is one you can depend on.

Different types of collaborations find different ways to involve consultants. Following are some examples of how consultants can help collaborative efforts:

- **Facilitator:** Consultants often help facilitate discussions between the collaborative partners, freeing the participants from having to focus on the process of their interaction. A consultant in this role can "break the ice" on difficult topics, ensure that all viewpoints are heard, encourage accountability, and keep things moving and focused.
- **Researcher:** Collaborative partners might ask a consultant to do research or analysis that is either unfamiliar, too time consuming for the partners, or is best done by an outsider. For example, a collaborative fundraising effort may have a consultant research funding prospects, while a merger feasibility effort may ask a consultant to conduct focus groups among clients.
- **Extra pair of hands:** In some cases a consultant can be useful carrying out tasks that the partners simply do not have time to do. Examples include writing grant proposals, investigating sites for program events, writing publicity materials, writing up notes from group meetings.
- **A neutral set of eyes:** In some cases, groups can spend all their time on conflicts, real or imagined, or be overly polite and avoid dealing with important differences or conflicts. A consultant can serve collaborating groups by bringing an objective, neutral perspective to the mix, going beyond the facilitative role to offer input into the discussions and helping to manage conflict.
- **Mediator/Shuttle Diplomat:** If the partners are fighting but must still work together or resolve some issues, they may need to utilize a consultant to help them bring the disputed matters to a close.
- **Expert:** Collaborative partners may find it helpful to have an expert "on retainer," or brought in to advise on a particular topic. For example, a managed care consultant can help two agencies evaluate their combined ability to compete for HIV service contracts with HMOs, or a fundraising consultant can help two agencies put together a benefit.

When hiring consultants, consider the following tips:

1. Interview at least two consultants, preferably one suggested or known by each agency. You'll be able to explore different approaches to the project, and may find yourselves utilizing the ideas of more than one consultant.
2. For substantial projects, ask for references and a written price bid from each consultant interviewed.
3. Agree on one person to whom the consultant will report. The consultant will get confused if different partners are asking for different things, and there is a danger the partners will end up trying to negotiate through the consultant rather than directly.

4. Have a written MOU or contract with the consultant, with payments based on the consultant's performance of agreed-on tasks.
5. Periodically ask the other collaborative partners how they are feeling about the project with the consultant. For example, one partner may have kept silent about complaints believing the others to be satisfied.
6. Throughout the project, give the consultant feedback about his or her work.
7. Don't expect a consultant to make tough decisions or value-based choices for you. A consultant can help articulate alternative courses of action and the implications of various choices, but the collaborating partners should make the decisions themselves.
8. Agree in advance on how you will pay the consultants' fees, including any overruns.

4. Merger And Consolidation

- **Questions & Answers About Mergers**
- **Seven Steps in a Merger Process**
- **Assessing the Feasibility of a Merger**

At the far end of the collaborative continuum is the merger of two or more organizations into a single organization. Sometimes a smaller organization will merge into a larger organization, becoming a program or division of that organization. In other cases, two or more organizations will cease being independent, and a new organization will emerge.

QUESTIONS & ANSWERS ABOUT MERGERS

Q: How do mergers get initiated?

A: In many cases, a funder will be the first to bring up a possible merger. The funder may suggest the idea to one organization without an idea in mind for a possible partner or the funder may encourage two organizations to explore the idea of merging. In other cases, it's usually the executive director or a board officer who "breaks the ice" on the idea of merging with another organization. Practically speaking, many merger discussions begin when one organization is in financial difficulty, or when one organization loses its executive director.

Q: What are the "Go/No Go" questions for a merger ?

A: • Will services to clients be improved or expanded if a merger occurs?
• Will a merged organization be more competitive for funding, managed care contracts, or other resources?

Q: In deciding whether to merge, should we consider whether administrative costs would be reduced, or how the boards are organized, different organizational cultures, etc.?

A: These questions are really about how difficult a merger would be, and how to structure a merger

process, rather than about *whether or not* to merge. Client services now and in the future should be the central focus of a decision about merger.

Q: How can we go about exploring the idea of a merger with another organization?

A: Sometimes informal conversations between staff or board members of the two organizations will generate discussion simultaneously in both agencies. In those cases, it makes sense for both board presidents and/or both executive directors to get together and discuss whether a merger should be explored at all. In other cases, the idea will emerge in one organization, and the board will authorize its president and/or executive director to contact the other organization to explore the possibility of a merger.

Q: What are the basic steps in a merger process?

A: The steps are as follows:

SEVEN STEPS IN A MERGER PROCESS

1. **Initial exploration**
2. **Feasibility phase**
3. **Intent to merge resolutions**
4. **Merger planning**
5. **Decision to merge**
6. **Merger**
7. **Post-merger adjustments**

1. **Initial exploration:** After the informal conversations have become serious, the process formally begins: both boards pass resolutions to explore the possibility of a merger. They may draw up and sign a Memorandum of Understanding (MOU), which clarifies the scope of their agreement (the nature of the exploration that will take place), and provides a basis for communicating with funders and other stakeholders. Or each board may pass a resolution authorizing more serious exploration and study to take place. The important thing is that the board officially "signs on" to the *possibility* of merger.

2. **Feasibility phase:** Whether the feasibility is considered by an outside consultant, by a joint subcommittee of board members from both agencies, or by a joint staff committee, the following questions are typically addressed:

   - Will client services be enhanced or expanded in the event of a merger? In what ways?

   - To what degree do the programs of the two agencies overlap in populations served and in services provided? If it's possible to determine without violating client confidentiality; to what degree do both organizations serve the same individuals?

   - In what ways would the programs of each agency be able to draw upon the expertise, location, clients, reputation, and other resources of the other organization?

- In what ways are the approaches to clients and the community similar and different between the two organizations?

- Will a merged organization be more competitive for funding, managed care contracts, or other resources than the two organizations are now?

- To what degree do government, foundation, corporate and individual donors overlap? What is likely to be the impact on funding of a merger? Of a decision not to merge?

- In the event of a merger, what short-term costs and savings can be anticipated related to administration? Long-term costs and savings?

- What conditions will facilitate a merger? What obstacles will need to be overcome? How could a merger process address these issues? The list of issues begins with the following:
  - Composition, size, policies and operating style of the boards
  - Will an existing executive director be chosen? If so, what will be the role of the other executive director? What about for other positions, such as program director, development director, etc.?
  - Location
  - Name of new organization
  - Financial aspects: revenue streams, expense levels, cash positions, fixed assets, debt, etc.
  - Discrepancies in salary levels and benefits

3. **Intent to merge resolutions:** If the organizations decide to go ahead, both boards pass resolutions expressing their Intent to Merge, and to proceed in good faith with determining a detailed process for the merger and what the merged organization will look like. A "Transition Steering Committee" or "Merger Task Force" is formed with representatives from both organizations, and both organizations agree on a statement to staff, clients, funders and the community about the expectation that a merger will occur. Note: though the option to "back out" remains, the groups are saying, "Unless something unexpected comes up, we will go ahead and merge."

4. **Merger planning:** This planning phase includes what lawyers call "due diligence," where each side reviews the financial records of the other, current contract obligations, etc. In addition, staff begin meeting to plan how programs and administration will be merged. A detailed plan is developed by the Steering Committee or Task Force that includes:
   - Detailed plan for staffing the new organization
   - Detailed plan for merging the two boards of directors
   - New name (if applicable)
   - Appropriate legal process for merger
   - Plan for informing funders, clients, other agencies, etc.
   - Plan to acquire any funds needed to support the merger
   - Public relations plan

5. **Decision to merge:** Both boards make final votes for merger. Plans from the Steering Committee or Task Force are revised and approved. The form of this final resolution is often called a "Letter of Agreement."

6. **Merger:** New corporate forms are activated and boards merge. Merger of operations is phased in as planned.

7. **Post-merger adjustments:** Staff and board members work towards creating the new organization—merging procedures, accounting systems, program groups, board committees, and perhaps most importantly, organizational cultures. This process, usually taking several months at a minimum, will have some "bumpy" periods, and requires both commitment to the newly emerging organization as well as strong leadership and conscious attention to working through processes.

Q: How long does a merger take?
A: The formal legal procedures take a matter of weeks, but a year-long process is not uncommon for groups who begin with serious intent. We know a group of agencies which has now begun final legal procedures, after five years of on-again, off-again conversations, meetings, and study.

Q: What about the legal aspects of the merger? How does it actually occur?
A: If a decision is made to proceed with a merger, there are several ways the legal process can be completed. Perhaps the simplest is for one organization to close and to assign all its assets and liabilities to the other organization. The "acquiring" organization can change its name, Articles of Incorporation, and bylaws to a set determined by both boards jointly. The board members of the closing organization would be elected to the board by the acquiring organization, and staff members of the closing organization hired by the acquiring organization. Although technically an acquisition, this process can be described and implemented in all other ways as a merger. A toss of the coin can determine which corporate entity will close and which will acquire the closed entity. The advantage of this route is that the time and expense of dissolving both organizations and incorporating a new one are saved.

If a new corporate entity is formed to succeed the two existing organizations, it must obtain federal and state tax exempt status (a process taking four to eight months). Each of the two existing corporations would close and transfer their assets and liabilities and contractual obligations to the new corporation. On a pre-determined date, the new corporation would hire all existing staff from the two organizations and assume responsibility for existing activities and contracts. Generally, the only reason organizations choose this route is to provide "psychological independence" from either of the two organizations; it is the same idea as when a couple decides to live together and chooses to get a new place, rather than live in either of the existing homes, so they can start "fresh."

Regardless of which process is selected during the transition period, discussions with government funders, foundation funders, lessors and others will result in specific transfer processes and timelines which may not be exactly in accordance with the corporate transfers. For example, to simplify paperwork, it may be advisable for existing government contracts to be completed under the "old" corporate entities, but delivered through subcontracts to the "new" corporate entity.

Imagine that three organizations begin a discussion about a merger. All three agencies go through the first two steps together. After the feasibility study, one group decides not to go forward. The two remaining groups then continue with planning, decide to merge and implement the merger. After the merger, the new organization is born and begins the inevitable process of post-merger adjustments.

	1. Initial Exploration	2. Feasibility	3. Intent to Merge	4. Merger Planning	5. Decision to Merge	6. Enact Merger	7. Post-merger Adjustments
Agency 1	➡	➡	Yes	➡	➡	➡	➡
Agency 2	➡	➡	Yes	➡	➡	➡	
Agency 3	➡	➡	No				

ASSESSING THE FEASIBILITY OF MERGER

The first part of assessing feasibility is agreeing on the critical questions to be answered. The list provided here should be used as a starting place, you may have other questions to resolve. The second part of the feasibility assessment is determining how to get the information you need to answer the feasibility questions. Below is a sample worksheet which includes several different ideas about how each question might be addressed.

Worksheet

Merger Feasibility Worksheet

MERGER FEASIBILITY WORKSHEET	**How can we answer this question? Information needed, discussions to be organized, advice to be sought?**
Will client services be enhanced or expanded in the event of a merger? In what ways?	*Examples:* • Focus groups with clients of each agency asking what services they would like to see added • Interviews or focus groups with line staff about multiple services to same clients
To what degree do the programs of the two agencies overlap in populations served and in services provided? If it is possible to determine without violating client confidentiality; to what degree do both organizations serve the same individuals?	*Examples:* • Analysis of population types served and percentage of those populations served • If possible within client confidentiality guidelines, analysis of individuals served with which services for overlap and possible synergies
In what ways would the programs of each agency be able to draw upon the expertise, location, clients, reputation, and other resources of the other organization?	*Examples:* • Group and individual interviews with staff, other HIV agency staff and community leaders

MERGER FEASIBILITY WORKSHEET (CONTINUED)	
In what ways are the approaches to clients and the community similar and different between the two organizations?	*Examples:* • Interviews with staff of both agencies, clients of both agencies, community members • Observation by third party of activities such as support groups • Review of printed, video and other materials to identify and classify approaches
Will a merged organization be more competitive for funding, managed care contracts, or other resources than the two organizations are now?	*Examples:* • Interviews with local, regional and national foundation, corporate and government funders • Interviews with local health care providers, analysts • Interviews with other agency fundraisers, fundraising consultants
To what degree do government, foundation, corporate and individual donors overlap? What is likely to be the impact on funding of a merger? Of a decision not to merge?	*Examples:* • Analysis of funding and giving records • Interviews with major donors
In the event of a merger, what short-term costs and savings can be anticipated related to administration? Long-term costs and savings?	*Examples:* • Analysis of administrative staff costs for overlapping positions (such as Executive Director, Receptionist) • Identification of existing or emerging gaps (such as Personnel Manager) • Analysis of costs directly related to the merger, such as filing fees, debt assumption
What conditions will facilitate a merger? What obstacles will need to be overcome? How could a merger process address these issues? The list of issues begins with the following: • Composition, size, policies and operating style of the boards • Will an existing executive director be chosen? If so, what will be the role of the other executive director? What about for other positions, such as Program Director, Development Director, etc.? • Location • Name of new organization • Financial aspects: revenue streams, expense levels, cash positions, fixed assets, debt, etc. • Discrepancies in salary levels and benefits	*Examples:* • Compare composition policies of the boards, including terms, term limits, demographic requirements, officerships and committee structures; recommend transition phases and new structure • Analyze assets and liabilities of both organizations for complementary or duplicative financial strengths and weaknesses • Compare salary level discrepancies for similar positions and quantify cost of bringing lower salaries to par • Identify elements to keep in a new name and recommend a process for selecting and publicizing a new name

HIV Prevention Community Planning: Collaboration and Beyond

1. Why Community Planning?

- **Why should we get involved?**
- **What is HIV Prevention Community Planning?**
- **The "Guidance" for Community Planning**

This section answers the question busy and over-burdened staff and volunteers of ASOs have: why and how should I get involved with community planning? The section also provides a synopsis of the "guidance document" which prescribes how community planning should be conducted.

WHY SHOULD WE GET INVOLVED?

> "This is the table that is going to set the vision and the priority for the prevention of AIDS in your community. If you're not there, the voice of your community won't be heard at that table. You have a responsibility that isn't just about you and your agency, but about your clients. Your responsibility is to be their voice. *If you don't speak up, they won't be heard.*"

So says Paul Kawata, the Executive Director of the National Minority AIDS Council (NMAC). He calls Community Prevention Planning a "grand experiment. We don't know yet if it's going to work. We do know that what WAS happening didn't work. We hope that community planning is a better way because it brings diverse players to the table to collaboratively figure out the answers."

The fact that we have community planning councils across the country is a hard-won victory for AIDS activists who were determined to see strong, local community participation in the allocation of federal funds for AIDS prevention and care. Participating in these community planning groups can be exhilarating and satisfying as well as confusing and frustrating. What is community planning all about, and how can you be involved?

WHAT IS HIV PREVENTION COMMUNITY PLANNING?

Beginning in January, 1994, 65 state, local and U.S. territorial health departments which had received HIV prevention funding from the Centers for Disease Control and Prevention (CDC) were asked to seek significant and meaningful involvement of their communities in developing comprehensive HIV prevention plans.

What community planning groups do is to establish *priority needs and service areas,* in order to develop *comprehensive prevention plans* for their jurisdiction, whether local, regional or state. They have a crucial role in *developing public policy* at all levels of government regarding HIV prevention and care.

The required and suggested processes are outlined in a document called the *Guidance*, published by CDC.

THE "GUIDANCE" DOCUMENT

Though the title makes it sound like the basis for religious instruction, the *Guidance* is nothing more than a fifteen page document which serves as the "operating instructions" for all 65 HIV Prevention Community Planning groups in the country. Formally known as the "Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects," the *Guidance* outlines a process whereby the identification of high priority prevention needs is shared between the health department administering HIV prevention funds and representatives of the communities for whom the services are intended. The document itself was developed in collaboration with both governmental and non-governmental organizations.

While the *Guidance* allows health departments some leeway in designing a community planning structure that "best fits the needs of their jurisdictions," all planning efforts must follow the 13 principles of community planning identified in the *Guidance*. It also outlines planning steps which should be followed, and defines elements of a comprehensive HIV Prevention Plan. We include the 13 principles and the elements of a comprehensive plan to provide an idea of the operating instructions community planning group members must become familiar with in the course of their work.

The 13 Principles of HIV Prevention Community Planning

1. HIV Prevention Community Planning represents an ongoing process.

2. HIV Prevention Community Planning reflects an open, candid, and participatory process, in which differences in background, perspective and experience are essential and valued.

3. HIV Prevention Community Planning is characterized by shared priority-setting between organizations administering and awarding HIV prevention funds and the communities for whom the prevention services are intended.

4. Each grantee is required to identify at least one HIV Prevention Community Planning group (consideration should be given to the use of planning bodies/processes already in place) which reflects in its composition the characteristics of the current and projected epidemic in that jurisdiction (as evidenced in reported AIDS cases; HIV data, if available; and/or relevant surrogate markers). Other members of the planning group(s) should include scientific experts, service providers, and organizational representatives.

5. Nominations for membership are identified through an open process and candidates are selected based on criteria delineated in the application request for HIV community planning funds. In addition, the recruitment process for membership in the HIV Prevention Community Planning process is proactive to ensure that socioeconomically marginalized groups, and groups that are underserved by existing HIV prevention programs, are represented.

6. From the outset, all members of the HIV Prevention Community Planning group(s) understand the roles and responsibilities as outlined in this guidance and agree to the procedures and ground rules used in all deliberations and decision making.

7. The starting point for defining future HIV prevention needs begins with an accurate epidemiologic profile of the present and future extent, distribution, and impact of HIV/AIDS in defined, targeted populations within the grantee's jurisdiction. In defining at-risk populations, special attention should be paid to distinguishing the behavioral, demographic and racial/ethnic characteristics.

8. Identification, interpretation, and prioritization of HIV prevention needs reflect culturally relevant and linguistically appropriate information obtained from the communities to be served, particularly persons at risk for HIV infection and persons with HIV disease.

9. Assessment of HIV prevention needs is based on a variety of sources (both qualitative and quantitative), is collected using different assessment strategies (e.g. surveillance; survey; formative, process, and outcome evaluation of programs and services; outreach and focus group(s); public meetings), and incorporates information from both providers and consumers of services. Techniques such as oversampling may be needed to collect valid information from certain at-risk populations.

10. Setting priorities for specific HIV prevention strategies and interventions is based on the following criteria; (a) documented HIV prevention needs based on the current and projected impact of HIV/AIDS in defined populations in the grantee's jurisdiction; (b) outcome effectiveness of proposed strategies and interventions (either demonstrated or probable); (c) cost effectiveness of proposed strategies and interventions (either demonstrated or probable); (d) sound scientific theory (e.g., behavior change, social change, social marketing theories); (e) values, norms, and consumer preferences of the communities for whom the services are intended; (f) availability of other resources.

11. Resources are provided to support all steps in the community planning process as listed, including facilitating the involvement of all participants in the planning process, particularly those persons at risk for HIV infection and persons with HIV disease.

12. Specific policies and procedures for resolving disputes and avoiding conflict of interest identified by the grantee or the planning group(s) are consistent with the principles of this guidance, and are developed with input from all parties.

13. The HIV Prevention Community Planning process includes the following evaluation components throughout the course of the project period: (a) developing goals and measurable objectives for the planning process; (b) monitoring the objectives; (c) evaluating the operation of the process; (d) evaluating the impact of the planning process; and (e) assessing the cost of the process.

The 9 Elements of a Comprehensive HIV Prevention Plan

1. An HIV/AIDS epidemiologic profile that reflects the current and future epidemic in that jurisdiction.

2. A description of target populations to be reached by primary HIV prevention interventions.

3. A description of priority individual, group, and community-level strategies and interventions that are culturally and linguistically appropriate for defined target populations whose serostatus is unknown, negative or positive.

4. A description of how primary HIV prevention activities are linked to secondary HIV prevention activities, i.e., activities to prevent or delay the onset of illness in persons with HIV infection.

5. Goals and measurable objectives for both the short-term (budget period) and long-term (project period).

6. A description of other HIV prevention-related activities, and how these are linked in the geographic area for which the plan is developed.

7. A description of how public and non-governmental agencies will coordinate within the area for which the plan is developed to provide HIV prevention services and programs.

8. An HIV prevention technical assistance plan identifying needs of grantees and community-based providers in the areas of program planning, implementation and evaluation.

9. An evaluation plan for the HIV prevention planning process as delineated in this guidance.

2. The Fundamentals of Community Planning

It's About Outcomes

- Applying the Four Rules for Successful Collaboration to Community Planning
- The Critical Role of Leadership
- The 18 Habits of Highly Effective Co-Chairs
- Voice of Experience: "Our idealism has been tested, yet remains true"

It's About Relationships

- Guidelines for Building a Group Identity in Community Planning
- Engage Your Health Department in the Community Planning Process
- Voice of Experience: "I've known these people a long time"

It's About Power

- Parity, Inclusion and Representation
- Voice of Experience: "Getting the 'forgotten' people involved"

This section answers the question of many busy and over-burdened staff and volunteers of ASOs: Why should I get involved with community planning? The section also provides a synopsis of the "guidance document" which prescribes how community planning should be conducted.

IT'S ABOUT OUTCOMES

Applying the Four Rules for Successful Collaboration to Community Planning

Yes, the four rules for successful collaboration discussed above still apply; they simply need to be applied to the environment of community planning.

1. The scope of the collaborative project is clearly defined.

The scope of the planning process is potentially vast. Not only is comprehensive planning required, but coordination *between* community planning groups is also sought. As a member of a prevention planning group it is important to set realistic goals for each year of planning.

=> As a chair, make sure the annual work programs for the community planning group as a whole are written down and monitored.

=> As a member of the community planning group, make sure you understand the work before the community planning group, make sure any committee assignments you take on are congruent with the goals of the entire community planning group.

2. Each partner is clear about how the collaboration will advance the interests of its organization and clients.

Application of this rule is tricky because community planning group members are expected to bring their own experience, perspective and interests to the table *and* to work with the other members to develop a community-wide perspective. The potential for conflicts of interest is built in: agencies vote on how to prioritize needs which they compete to serve, "consumers" vote on how to prioritize services which they use, and activists and scientists vote on how to prioritize strategies which they often argue over. How can this work? The process works best when individuals can be honest about their own "agendas" but are willing to work with others to develop sound, comprehensive plans.

=> As a community co-chair ensure that individual members have opportunities to express their individual interests as part of the process seeking group decisions.

=> As a member of the community planning group, feel free to advocate on behalf of a particular group or point of view, as long as you are willing to listen with an open mind, to the views of others; you cannot choose to serve *either* the interests of a sub-group *or* the interests of the community at-large: you must balance the interests of *both.*

3. Roles and responsibilities have been well defined; suitable mechanisms for communication and joint accountability are in place.

The structures of community planning groups are often quite intricate. Members sit on committees, sub-committees and coordinating steering committees, health department staff work in both support roles and in decision-making roles, and often one or more consultants is involved. Simple things like keeping a current organization chart, and sharing minutes from the meetings of all the various groups help enormously in keeping responsibilities clear and participants accountable to each other.

=> As a community co-chair, keep asking your fellow community planning group members if they understand their roles and responsibilities; you will be astonished at how often members will want additional clarification, and you will do the entire group a great service by clarifying, over and over again if necessary, who is supposed to do what by when!

=> As a member of the community planning group, take it upon yourself to ask for clarification when you need it, and to help your fellow planning group members stay focused; your co-chairs will appreciate all the help they can get in this area!

4. The relationship "works:" trust and respect among the key players are sufficient to support the level of risk and interdependence involved in the project.

Getting work done in a "committee" of thirty to forty people is a daunting challenge. Especially when you consider that members often bring with them a distrust of other individuals or groups of individuals. Building a sense of teamwork takes time, and time is often short. Still, planning groups over the past few years in urban, rural, local and state councils have shown that good work can get done.

=> As a community co-chair, review the 18 Habits of Highly Effective Co-Chairs regularly, share feedback with your fellow co-chairs *and* stay open to the feedback of your fellow planning group members.

=> As a member of the community planning group, be a consistent participant; it takes time to get to know the other members and inconsistent attendance greatly hinders the development of productive working relationships.

The Critical Role of Leadership: 18 Habits of Highly Effective Co-Chairs

by the NMAC Technical Assistance Department

In order for the community planning group to abide by the four rules for successful collaboration, the co-chairs have a central role to play. The following "habits of highly effective co-chairs" were compiled by the NMAC T.A. Department in collaboration with the National Association of State and Territorial AIDS Directors. In addition to providing sound and practical advice, co-chairs might use this list for periodic review, to look for ways to sharpen and improve your skills as a leader for your planning group.

1. **Fine tune facilitation skills** - Take a course or use good facilitators; they can help to make the process a little smoother.
2. **Read the guidance** - This document will really educate you about the process. Also read other resources on Community Planning.
3. **Identify the strengths of each co-chair and member and try to capitalize on them** - e.g. motivation, communication, facilitation.
4. **Utilize the talents and skills of the group** - use epidemiologists to interpret and provide data at a comprehensive level for the group; use teenagers to develop interventions for their peers.
5. **Try to develop and apply new areas of strength among planning group members.**
6. **Encourage planning group members to play an active role in the planning process** - Occasionally go around the table and allow and encourage individuals to participate in the discussion and decision making process.
7. **Identify technical assistance needs and request technical assistance (TA) from providers** - a list is provided in this manual.
8. **Use time efficiently at meetings** - Attend a training on conducting effective meetings or sponsor an in-service training on conducting an effective meeting. This will help increase productivity and ensure efficient meetings. Local and national TA providers are a good resource for this.
9. **Debrief with your co-chair before and after the meeting** - This will help build understanding and enhance communication between the two co-chairs and enable you to make sure the process stays on course.
10. **Gauge the success and progress of smaller committees** - Check in often with committee chairs and offer support where needed.
11. **Encourage partnerships among the community, health department and private agencies.**
12. **Consider having a "co-chair in waiting" or a "co-chair-elect" to provide a period of time (even a year) where a planning group member can prepare to become a co-chair.**
13. **Don't be afraid to ask questions** - Whether it's an acronym or another issue, just ask.
14. **Maintain atmosphere where everyone on the planning group is encouraged and feels safe asking questions.**
15. **Believe in yourself and your abilities** - Know that each of you has something important to contribute to this process.
16. **Acquaint yourself with local, regional and national HIV/AIDS issues** - This also includes the collateral issues of poverty, substance abuse, etc. Knowledge of these issues can be beneficial to the decision-making of the group.
17. **Build upon and value diversity of membership by promoting and celebrating parity, inclusion and representation of group members** - Create a space where group members can share their knowledge through their own experiences. That's what we're here for!
18. **Involve the larger community in the partnership** - Use town hall meetings, public relations campaigns, focus groups and other methods to extract information for your plan.

VOICE OF EXPERIENCE: "OUR IDEALISM HAS BEEN TESTED, YET REMAINS TRUE"

Luoluo Hong is the Community Co-Chair of the Louisiana Region II prevention community planning group. Most members, says Luoluo, joined the planning process motivated by similar ideals of healing our communities, improving the health of our loved ones, and raising the awareness of all citizens. "One year later, that idealism has been tested, yet remains true."

In their first year, the members of the Louisiana community planning group struggled with "political agendas (some subtle, others overt), territorialism, hot weather, suspicious community leaders, attack dogs, grandmothers with grit, and tension-filled meetings. Along the way, we laughed, cried, fought, and hoped together."

The group stayed focused on its priority outcomes and delivered its year two plan to the state Office of Public Health on time. Luoluo says that the community planning process "helped each of us involved to grow as much as it enabled each of us a chance to give back to the people we called friends, teachers, mentors, neighbors, grocery store clerks, cops, and family."

IT'S ABOUT RELATIONSHIPS

The five tips for negotiating and managing collaborative partnerships also apply in the environment of community planning. However, the situation is made much more complex by the fact that the "negotiation" is taking place among many parties all at the same time. What is persuasive to one person may have no meaning for another. What seems to one person like creative effort to discover mutual gain may seem like stalling to another. And even the words one person uses may convey different meanings to another.

How can this situation be managed productively? First, there are two extremes to avoid. Large groups tend to "manage" themselves either by becoming overly dependent or overly independent. That is, they tend to submit to a dominating leader or to refuse to accept any leadership and get mired in chaos. The challenge is to *balance* the tension between submitting to authority and refusing to accept leadership.

Clearly, the appointed or elected leaders have a central role here. They must abide by the four rules of collaboration, and they must accept responsibility for leading the group. The tips on effective co-chair leadership above all speak to specific steps leaders can take.

However, each member has an essential role to play as well. The leaders cannot do their jobs if the group members do not participate constructively. The dynamics of the group are heavily influenced by the ways in which group members treat each other and the process. Below are two sets of tips: one is a set of ground rules which all group members can use, the second speaks specifically to the tensions which often arise between health department professionals and "community" members.

GUIDELINES FOR BUILDING A GROUP IDENTITY WITH YOUR COMMUNITY PLANNING GROUP

Building a group identity does not mean that everyone has to agree with everyone else. Congress has a strong group identity, they make decisions by very detailed rules and their authority is quite carefully spelled out. Unanimity, or consensus, however is not something that happens very often in that "planning body!"

Community planning groups often assume that they must come to unanimous decisions. That is not necessary. What is necessary is that each planning group member can support the decisions the whole group makes, even if he or she does not agree with every one. The following guidelines for developing a productive group process and group identity are adapted from work by Deborah L. Johnson. These guidelines are equally valid and helpful for community planning group co-chairs and for members of planning groups.

- **Unanimity is not a requirement.**
  In a collaborative environment, individuals must retain their own identity *and* accept an identity as a member of the larger group. Thus, do not insist on unanimity for every decision, disagreement is essential to creativity and free speech. Do, however, insist on constructive and consistent participation.

- **People don't have to like each other to work effectively together.**
  Often individuals have no desire to develop an identity that aligns them with those whom they distrust. If the group process is experienced as fair, and relatively open to input from all members, the group can function even if many of the individuals do not get along well personally.

- **Group process needs to be culturally acceptable to all members.**
  Developing a group identity in a collaborative environment requires that processes, especially ground rules and decision-making processes be culturally pluralistic. Take care to create a mode of operation which reflects the diversity of values and sensitivities of those participating.

- **Help members get to know one another as individuals.**
  Individual identity is multi-dimensional. In group processes, individuals often bring to the table a multitude of perspectives. Group process is enriched when participants are able to see the vast array of expertise among them that is not always reflected in job titles. Provide opportunities for members to get to know each other so that they can better understand each other and make better use of all the life experience in the group.

- **Develop a feedback loop about group process.**
  Activities, in and of themselves, are not enough to build a cohesive group identity. The group needs to "learn" how to be a group through a combination of work experience and reflection.
  => The group process should be structured in such a way as to monitor and provide feedback on the working dynamics of the group, with special attention paid to how the group resolves and prevents conflicts. An external "process" consultant can provide this type of feedback. Or the group can periodically "check itself" regarding the way it is working together.

ENGAGE HEALTH DEPARTMENTS IN THE COMMUNITY PLANNING PROCESS

One of the major "cultural" divides that sometimes splits community planning groups into factions is the line between the health department professionals and everyone else—the "community." In many communities the relationship between the health department and members of the community have been less than collaborative. The potential for partnership, and unified effort, between community members, CBOs and the government lies on the other side of this "us and them" divide.

1. Get to know the health department staff you are working with as people.

2. Find ways to tap the diversity and breadth of experience in health departments.

3. Try to learn the "organizational culture" of the health department and understand the relationship of the AIDS division to the larger health department.

4. Be clear on what the health department is responsible for as stipulated in the CDC *Supplemental Guidance.*

5. Be sure to give positive feedback when health department staff provide valuable support, whether it's bringing pizza to a meeting or developing sophisticated epidemiological profiles.

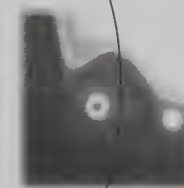
In particular many state and local health departments have provided a wide variety of support to the community planning process. The following are examples of support you may be able to get from your health department.

Examples of Leadership Support
- maintain open lines of communication with public health professionals
- provide guidance and support to co-chairs
- involve the various parts of the health department in the process
- ensure the planning group fully understands its role and responsibilities

Examples of Technical Support
- provide epidemiological information
- assemble a profile of existing community resources
- provide support in conducting needs assessments
- translate planning group decisions into a draft, written, comprehensive HIV prevention plan

Examples of Administrative Support

- develop a comprehensive work plan with targeted completion dates
- handle the logistics of setting up meetings
- duplicate and assemble materials for planning group members
- serve as recorder during meetings and transcribe minutes



VOICE OF EXPERIENCE: "I'VE KNOWN THESE PEOPLE A LONG TIME"

AIDS In Minorities (AIM) was one of the first African American community-based organizations dealing with AIDS in the state of Alabama. Located in Birmingham, AIM was founded in 1987.

Tony Morris, now the Executive Director of AIM was a founding board member. "We chose to identify ourselves primarily as an African-American organization, rather than as a gay and bisexual group because homophobia is so strong in the south. When other organizations were having difficulty working with black churches doing outreach and AIDS education, we had fewer problems."

AIM now has active partnerships with the local health department, the local university and other AIDS service organizations. Tony has been involved with prevention community planning since its inception.

Tony is currently a Prevention Planning Council Co-Chair and he is well aware of the difficulty in developing trusting relationships among the group. "What with the Tuskeegee study and all, there is not a lot of trust in health care professionals among African-Americans." Still, he says that the community planning group is doing a good job overall and that part of the reason for the productive working relationships they have built is that many of the people involved now have been involved for several years. "I was around in the beginning and I've known a lot of these people for a long time. My philosophy is 'let's just try to focus on what we're doing, and do it well;' we are in business to render service to people who need it."

IT'S ABOUT POWER

In a group process we must come back to issues of power. As in the discussion about power in other collaborative projects, there are often stark differences in power and influence among members of a community planning group. The CDC was not unaware of this in setting up the guidance for the prevention planning process. However, understanding the need to balance power, and achieving a dynamic balance of power are two different things.

Three dimensions of group process and membership which have received the most attention are parity, inclusiveness and representation.

Parity, Inclusion and Representation (PIR)

The definition of "participatory planning" is an ongoing process in which state/local health departments share responsibility for developing a comprehensive HIV prevention plan with other governmental and non-governmental agencies, and representatives of communities and groups at risk for HIV infection or already infected (AED, 1994). Key characteristics include a membership that is representative of all stakeholders; an attitude that values and uses differences; and shared learning, input, responsibility, and decision-making.

Parity is defined as the condition whereby all members of the HIV prevention community planning group have equal opportunity for input and participation as well as equal voice in voting and other decision-making activities.

Inclusiveness is defined as assurance that all affected communities are represented and involved in a meaningful manner in the community planning process.

Representation is defined as assurance that those who are representing a specific community truly reflect that community's values, norms and behaviors.

While these concepts seem simple and logical, they are challenging to put into practice. For example: which communities are "affected?" Some would say that everyone is affected, others would argue for a high incidence of AIDS as the definition of affected. Inclusiveness can be seen as a very broad principle or a very narrow principle.

(NMAC recommends that within the context of community planning, the definition of affected communities, or "consumers," should be broad. Community planning consumers therefore are not only people with HIV/AIDS, but those whose present and/or past behavior places them at high risk for HIV infection or transmission. Thus, consumers are members of specific groups targeted for HIV prevention messages or services, such as sexually active gay men, sexual partners of injection drug users, sexually active youth, women of color and former and present injection drug users.)

Similarly, while the CDC requires that "representation" consist of a "reasonable number" of representatives from particular communities, no individual can truly be said to "represent" an entire community, and most individuals belong to more than one community. Which group should a gay Asian male in recovery from IV drug use represent? Asians, people of color, gay men, IV drug users, all of the above? Trying to "count" the traits of representatives can be difficult.

Even the concept of parity becomes fuzzy when looked at closely. While it is possible to give everyone an opportunity to speak to certain issues, a group cannot claim equal opportunity for input and participation when epidemiologists debate matters of risk patterns with lay people from communities at greatest risk. The concept of parity requires an active "leveling of the playing field" to support all members in gaining the requisite knowledge to be constructive, active participants.

In spite of the difficulty of these concepts, community planning groups have developed strategies to pursue the lofty intent of participatory planning.

- **Connecticut's** planning committee will have 30 representatives but not all the slots will be filled through the nomination committee process. Some slots will be filled by planning committee members after their initial meeting. The state is interested in increasing the **inclusiveness** of the process by seeking input of people usually not asked to participate in a planning process, e.g. inmates and active IV drug users.
- **Texas** has 10 regional planning groups and a state group comprised of regional co-chairs. The regional groups meet to form a plan specific to their area, then the state group meets and combines individual plans to form the plan for the state. During the first year of community planning, Texas, like many other states, had problems with recruitment, not to mention parity, inclusion and representation. Beginning in January of 1995, the Texas Department of Health (TDH) began a con-

certed effort to bring all of the groups up to par on these issues. They have developed brochures, training videos and specific recruitment plans for each region to support appropriate **representation** of the local communities.

- **New York City** has their own prevention planning group of 55 members. However, the state of New York and the city share a "PWA" subcommittee group which meets regularly to discuss and act on prevention issues specific to people living with HIV disease. The committee reports back on suggestions to their respective groups. In addition to the fact that 20% of the 55 members are living with HIV disease, the work of the PWA subcommittee has given added weight and respect to opinions of the HIV positive membership. This supports **parity** in participation by PWAs.
- **Vermont** began its community planning process with a nominations committee consisting entirely of people with HIV disease. The policy regarding **representation** since then is to have a minimum of 25% of the members be people with HIV. In addition 30% of the planning group are people of color. Though people of color comprise only 2% of the state population, because the epidemic has spread disproportionately faster among people of color, the planning group has "weighted" its membership. Another unique aspect of the Vermont planning group is that most of the 30 members don't "work in AIDS." This means that fewer people come into the process with a preconceived idea of what prevention "should" look like. However, because members are not as experienced with the vocabulary and issues in prevention planning, all of the meetings have a training component. This brings about a better sense of **parity** in the group.

VOICE OF EXPERIENCE: "GETTING THE 'FORGOTTEN' PEOPLE INVOLVED."

Pandora Singleton was working for the Health Department in Savannah, Georgia in the late 1980s and early 90s. With the second highest AIDS caseload in Georgia, Pandora saw firsthand the cost of inaction by the government. She began with a small initiative which has blossomed into a highly effective advocacy organization for women and people of color, Project Azuka.

"I originally started out to form a support group for HIV positive women, and it just kept on growing."

One of the early issues Project Azuka tackled was the lack of involvement of people of color and people living with HIV on the local and state planning councils. Her goal was to start "bringing in people who have been forgotten."

Pandora invited, cajoled and pressured a large number of local organizations and institutions to support a conference designed to train potential advocates from the ranks of those "forgotten." The Social Security Administration, the AIDS Survival Project, Atlanta, the Health Department Case Management unit, and Georgia Women Preventing AIDS all took part, with supplemental funding from Ryan White.

At the conference, Pandora says, "many of these individuals were amazed and empowered that important people would come to talk to them. Now they are much more active on the planning councils.... Now it's different, we are seeing the positive stuff, more HIV positive people are talking out."

In addition, the institutions are learning that they can "no longer make decisions about people with AIDS without these people being involved."

For more information on the planning groups in your area:

Tip If you are not aware of how the HIV Prevention Community Planning processes are working in your area, begin by calling your city, county or state or health department. Or, you can contact the federal government directly for contacts in your local area. Centers for Disease Control and Prevention, Atlanta, Georgia: 1-800-311-3435

3. What is CARE? Title I? Title II?

- **CARE Title I, Title II**
- **Case Studies of Collaboration between CARE Councils and Prevention Councils**

This section introduces the reader to another type of HIV community planning group: those dealing with funding health care services for people living with HIV disease. Examples of interaction between health services groups and prevention groups are provided as examples of the range of options available to integrate these planning efforts.

CARE TITLE I, TITLE II

Beyond the HIV Prevention Community Planning Councils, there are planning councils and consortia for health services funded through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

- CARE Act Title I: Health Services-Local Planning Councils

  In 1990 Congress passed the CARE Act. Title I funding was provided to 8 counties and 8 cities across the country (called Eligible Metropolitan Areas or EMAs) where the epidemic had hit hardest (2,000 cumulative AIDS cases or a rate of 250 or more cumulative cases per 100,000 population). Subsequently increased to 49 EMAs, each locality was required to convene a Community Planning Council. $392 million was available to Title I grantees in FY 1996.

- CARE Act Title II: Health Services-State Planning Consortia

  In 1992 Title II of CARE Act was added to provide funding to all 50 states, the District of Columbia, Puerto Rico and Guam. Community input to the allocation process was required and all 53 jurisdictions developed some form of planning consortia. $261 million was available in FY 1996.

While both HIV Prevention Community Planning and CARE Act planning bodies have comprehensive planning responsibilities, they differ in terms of their role in the allocation of resources. In Prevention Planning, the Health Department has the sole responsibility for allocating resources, within the guidelines established by the comprehensive plan. However, under the CARE Act, Title I and Title II planning councils have the additional responsibility for establishing the allocation of resources across service priorities, though not to specific agencies within the service priorities.

CASE STUDIES: COLLABORATION BETWEEN CARE AND PREVENTION

In many jurisdictions, there are separate community planning groups for each type of funding. CDC estimates that during the first year of HIV Prevention Community Planning less than 10% of grantees merged the prevention and care planning processes. In the past two years, however, numerous planning bodies have devised methods of working together to better coordinate prevention and care strategies, services and funding.

These case studies were researched by MOSAICA in Washington, DC for the Division of HIV Services at HRSA in September, 1995.

Case 1: Michigan

Michigan is considered a medium-incidence state. It has a cumulative total of just over 7,000 reported AIDS cases, and an estimated 8,500 to 11,500 additional persons living with HIV disease.

The Michigan Department of Health has responsibility for both Ryan White Title II and the CDC cooperative agreement for prevention. A little over two years ago, the state was divided into eight geographic regions in order to provide care resources statewide. When the CDC Guidance was issued for prevention planning, the State retained those same defined geographic areas for prevention planning. The result was eight regional care consortia and eight regional planning groups, plus one statewide planning group for prevention and one statewide Title II consortium.

In the spring of 1995, the Governor's major advisory group on AIDS policies and budgets, the Risk Reduction and AIDS Policy Commission, directed the Health Department to begin to consolidate the efforts of these regional planning groups and care consortia over a two-year period. They did not specify rigid requirements for consolidation, but did lay out some minimum expectations, namely that while it was important to preserve both the agendas of CARE and prevention, the CARE consortia and Prevention Community Planning Groups must coordinate and collaborate effectively.

Case 2: Alabama

Alabama has established a coordinated prevention and care planning process. The state has Title II funding but no Title I EMA. Alabama is divided into eight public health areas and each area has an HIV Coordinator responsible for both prevention and care efforts. Each area has both a regional Title II consortium and HIV Prevention Community Planning Group.

To qualify for prevention or care funding, an agency is required to participate in a planning group. Since most agencies provide both prevention and care services, most are on both planning groups.

There is a statewide Title II consortium called the CARE HIV Advisory Council. No formal statewide prevention groups exists, but the co-chairs of the eight regional prevention planning groups meet as a group with the State Health Department to plan, coordinate and review the comprehensive prevention plan before it is submitted to CDC.

The prevention and care planning groups share information and collaborate on their needs assessment activities. The state has developed a suggested integrated needs assessment process which is carried out through one survey. The State Surveillance Branch prepares a regionalized epidemiological profile which is shared with both statewide groups.

The largely rural character of the state and limited number of community agencies conducting HIV activities, along with the state-coordinated public health area system which coordinates programs and information sharing are all cited by Alabama as factors supporting their collaborative planning approach.

Conclusion

AIDS has not only changed the face of medicine; community-based treatment and advocacy has changed the face of health care delivery. No longer are decisions about public health made behind closed doors solely by doctors and public health officials. Today, people living with AIDS, community-based providers, and representatives from a broad spectrum of the community are sitting at the decision-making tables with doctors, health officials, activists, and researchers.

"Participating in the community planning process is one of the most difficult, and one of the most important things I do," comments Steve Lew, Executive Director of Living Well Asian Pacific AIDS Project in San Francisco. "Our agency can–and does–do a lot of meaningful work. But through the CARE Council and the Prevention Council, we have a policy making impact on how the whole San Francisco community will deal with HIV for years to come." Steve's recent appointment to the President's Commission on AIDS is testament to the greater role that community-based providers can play in an open planning environment.

AIDS is fought on many fronts: in the laboratories, in medical clinics, in support groups, in families and neighborhoods, in board rooms and in city council chambers. Community planning is an important arena in the struggle.

Where to turn for more help

Organizations

National Minority AIDS Council
1931 13th Street, NW
Washington, D.C. 20009-4432
202-483-NMAC
fax: 202-483-1135
e-mail: nmactec@aol.com

Support Center for Nonprofit Management
706 Mission Street, Fifth Floor
San Francisco, CA 94103-3113
415-541-9000

Nonprofit Management Association
315 West 9th Street, Suite 1100
Los Angeles, CA 90015
213-623-7080
Call to find the management support organization nearest you.

Support Centers of America
706 Mission Street, 5th Floor
San Francisco, CA 94103
415-974-5100
Network of management assistance organizations, including centers in:
San Diego, San Francisco, Santa Barbara, Oklahoma City, Tulsa, Chicago, Ann Arbor, Atlanta, New Jersey, New York, Washington, D.C., Boston, and Providence.

Useful Written Materials

Fiscal Sponsorship: Six Ways to Do It Right, by Gregory L. Colvin, 1993.
Available from Study Center Press
1095 Market St., Suite 602
San Francisco, CA 94103
phone 800-484-4173; fax 415-626-7276. $12.95 plus $5.00 shipping and handling.

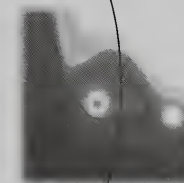
The Community Collaboration Manual by the National Assembly of National Voluntary Health and Social Welfare Organizations
1319 F Street, NW, Suite 601
Washington, D.C. 10004.
$10.95 plus $3.00 shipping and handling.

Getting to Yes, Negotiating Agreement Without Giving In, 2nd Edition, by Roger Fisher and William Ury, 1991.
Penguin Books.
$12.95 paperback at most bookstores.

How to Make Meetings Work, Michael Doyle and David Strauss, 1983.
New York, NY: Jove Books.
$10.95 paperback, at most book stores.

The Skilled Facilitator: Practical Wisdom for Developing Effective Groups, by Roger M. Schwarz, 1994.
Josey-Bass Publishers
350 Sansome Street, 5th Floor
San Francisco, CA. 94104-1342
$29.95 hardback + $4.50 shipping.

Strategic Planning for AIDS Organizations, by Jude Kaye and Mike Allison.
Published by the National Minority AIDS Council, 1994.
$15.00
National Minority AIDS Council (NMAC)
1931 13th Street, NW
Washington, D.C. 20009-4432
202-483-NMAC
or
Support Center for Nonprofit Management
706 Mission Street, Fifth Floor
San Francisco, CA 94103-3113
415-541-9000



Action Manual for Boards
by Jan Masaoka.
Published by the National Minority AIDS Council, 1995.
$15.00
National Minority AIDS Council (NMAC)
1931 13th Street, NW
Washington, D.C. 20009-4432
202-483-NMAC
or
Support Center for Nonprofit Management
706 Mission Street, Fifth Floor
San Francisco, CA 94103-3113
415-541-9000

Community Planning Resources

MOSAICA
The Center for Nonprofit Development and Pluralism
1000 16th Street, NW, Suite 604
Washington, D.C. 20036
202-887-0620

Manual for HIV Prevention Community Planning, prepared by The Academy for Educational Development, for the Centers for Disease Control and Prevention, Atlanta, GA. 1994.

The Centers for Disease Control and Prevention, National AIDS Clearinghouse:
1-800-458-5231

National Association of People with AIDS
1413 K Street NW, 7th Floor
Washington, DC 20005-3442
phone 202-898-0414
fax 202-898-0435
www.thecure.org

National Alliance of State and Territorial AIDS Directors
444 North Capitol Street, NW. Suite 700
Washington, DC 20001
202-434-8000

On-line Resources

Center for AIDS Prevention Studies, UCSF
http://www.caps.ucsf.edu/capsweb

Centers for Disease Control National AIDS Clearinghouse
http://cdcnac.aspensys.com:86/

CDC Funding Information
http://www.cdc.gov/funding.html

Yahoo's list of HIV resources on the Web
http://www.yahoo.com/Health/Diseases_and_Conditions/AIDS_HIV/

AIDS Treatment Data Network
http://health.nyam.org:8000/public_html/network/index.html

Project Inform
http://www.hivnet.org/informwww/index.html

About the Authors and the Support Center for Nonprofit Management

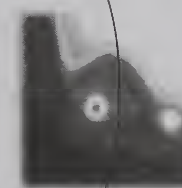
Mike Allison is the Director of the Support Center for Nonprofit Management's Consulting Group where he consults in the areas of strategic planning, boards of directors, organizational development and design and program evaluation. He co-authored *Strategic Planning: A Practical Guide and Workbook,* published by NMAC in 1984 and co-authored (with Jan Masaoka) *Why Boards Don't Govern,* a chapter in the University of Indiana's *Taking Trusteeship Seriously.* Mike has worked with several organizations on collaboration and merger projects and has worked extensively with both the HIV Prevention Planning Council and the CARE Council in San Francisco. He is the former executive director of a community-based organization, has a Masters in Public and Private Management from the Yale School of Management, and teaches Program Evaluation at California State University at Hayward. Mike is the Board Treasurer of Maitri AIDS Hospice in San Francisco.

Jan Masaoka is the Executive Director of the Support Center for Nonprofit Management where she works with a wide range of nonprofit organizations in financial management, boards of directors, program evaluation and increasingly, mergers and collaboration. She authored *Action Manual for Boards,* published by NMAC in 1995, and co-authored *Finance Manual for AIDS Organizations,* published by NMAC in 1993. Other published work includes articles in the *Chronicle of Philanthropy, Nonprofit Times, National Center for Nonprofit Boards Newsletter,* and other publications. Jan has experience as a consultant to mergers and collaborations as well as direct experience merging the Support Center for Nonprofit Management with two other organizations and negotiating several collaborative relationships. She is Treasurer of the Haigh-Scatena Foundation and an Advisory Council member of Living Well Asian Pacific Islander AIDS Services.

The Support Center for Nonprofit Management (SCNM), based in San Francisco, seeks to develop and support the creative, important work of the nonprofit sector. SCNM works with nonprofit staff and volunteers in collaboration, boards of directors, accounting and financial management, strategic planning, organizational development, meeting management, program evaluation and computer applications. Through consulting, workshops and publications, in 1995 the Support Center for Nonprofit Management held 550 workshops for Bay Area nonprofit managers and worked with over 200 nonprofits in consulting assignments. Special programs include the AIDS Agency management Assistance Project (AAMAP) which provides comprehensive, specialized services to HIV/AIDS service organizations, and Board Match Plus, which recruits and places individuals on boards of directors. Conferences on important topics for nonprofits have included such topics as managed care, the implications of new technology, and resource development for schools. Honored by *Inc.* magazine as one of 1995's ten best-managed nonprofits in the U.S., the Support Center for Nonprofit Management is a member of the national network Support Centers of America, the Nonprofit Management Association, and the Technology Resource Consortium.

Contact the **Support Center for Nonprofit Management** at:
706 Mission Street, 5th Floor
San Francisco, CA 94103-3113
Phone: 415-541-9000
Fax: 415-541-7708
email: supportcenter@supportcenter.org
www.supportcenter.org/sf/

Notes



Why Join NMAC?

NMAC is the only **national AIDS organization** dedicated solely and specifically to minority communities.

NMAC sponsors **award-winning conferences** including the *National Skills Building Conference, Our Place At The Table* and the *Prevention Summit.*

NMAC's TA department provides **unsurpassed technical assistance** and training to member CBOs.

NMAC's Public Policy department **protects your rights** on Capitol Hill.

NMAC's Treatment and Research department **advocates for better treatments** and treatment information in communities of color.

NMAC produces **national prevention education campaigns** directed at people of color living with HIV.

NMAC's membership of over 600 CBOs around the country provides members with **opportunities for networking and collaboration.**

NMAC produces **state-of-the-art technical assistance manuals** such as the "Strategic Planning Manual For AIDS Service Organizations" and the "Finance Manual."

NMAC's ongoing publications, **TA Newsletter and Update,** keep members updated on the latest events, issues and information in the fight against AIDS.

NMAC's Honorary Board Chair is Grammy award-winning artist, **Patti LaBelle**.

NMAC has created the, **"Women's Project"** to document and address the needs of women and families of color affected by HIV/AIDS.

NMAC is dedicated to using all of its resources on a national level to help develop leadership in minority communities to address issues of HIV/AIDS.

Why Join NMAC?

I WANT TO BE A LEADER IN THE FIGHT AGAINST HIV/AIDS!

By joining the National Minority AIDS Council, your organization becomes part of the powerful national voice of over 600 minority community based organizations fighting to win the war against AIDS. NMAC provides its members with representation on Capitol Hill, comprehensive technical assistance, innovative communications programs, a wide range of publications and a dedication to develop leadership within communities of color to address issues of HIV/AIDS infection. For more information contact the NMAC membership department.

NATIONAL MINORITY AIDS COUNCIL

SEND COMPLETED FORM TO:

1931 13TH STREET, NW, WASHINGTON, DC 20009-4432 • TEL 202/483-NMAC FAX 202/483-1135

Name ______________________

Title ______________________

Organization ______________________

Address ______________________

City ______________________

State ______________ Zip ________

Telephone ( ) ______________________

FAX ( ) ______________________

E-mail ______________________

Enclosed is my membership contribution of $____________. *See fees at right.*

❏ Check Enclosed

❏ Please charge my credit card:
❏ MasterCard ❏ VISA ❏ AMEX

Account # ______________________

Expiration ____________ Cardholder Name (Print) ____________

Authorized Signature ______________________

Non Profit Organization Membership Fees

❏ For Community Based Organizations and National HIV/AIDS-Related Associations:

IF YOUR ANNUAL BUDGET IS:	YOUR ANNUAL MEMBERSHIP FEE:
less than $250,000	$ 125
$250,000 to $500,000	$ 250
$500,000 to $1,000,000	$ 500
$1,000,000 to $2,000,000	$ 750
$2,000,000 and above	$1,000

❏ Health Departments

IF YOUR ANNUAL BUDGET IS:	YOUR ANNUAL MEMBERSHIP FEE:
less than $150,000	$ 125
$150,000 and above	$ 250

Notes

National Minority
AIDS Council

1931 13th Street, NW
Washington, DC 20009-4432
202-483-6622
202-483-1135 fax
nmactec@aol.com

The National Minority AIDS Council (NMAC) was formed in 1987 to develop leadership within communities of color to address issues of HIV infection. Its members are community-based organizations that deal with AIDS on the front lines – in hospitals and clinics, shelters and schools, storefronts and streets. Thousands of men and women of color rely on such organizations for outreach, care, education, housing and support services. NMAC's goals are to lend visibility, leadership, educational messages and materials, comprehensive technical assistance and a powerful national voice to these front line AIDS workers.

In partnership with the Centers for Disease Control and Prevention, NMAC has established a national initiative to provide technical assistance and training to minority community-based organizations (CBOs). The goal of NMAC's Technical Assistance Program is to build the capacity and strengths of minority CBOs throughout the U.S. and Puerto Rico.